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Minnesota's "Crack Baby" Law: Weapon of War or Link in a Chain?

Judith M. Nyhus Johnson*

History teaches that grave threats to liberty often come in times of urgency, when constitutional rights seem too extravagant to endure. The World War II relocation-camp cases, and the Red Scare and McCarthy-Era internal subversion cases are only the most extreme reminders that when we allow fundamental freedoms to be sacrificed in the name of real or perceived exigency, we invariably come to regret it.¹

Introduction

These are urgent times. Since Richard Nixon declared "war" on drugs in the late 1960s, American presidents have grappled with this difficult and widespread quasi-war.² Now homes are filled

* M.A., University of Minnesota; J.D., University of Minnesota, 1990. The author is a former childbirth educator who taught with a group affiliated with the International Childbirth Education Association (ICEA). Among the group's goals were a healthy mother, a healthy child, and a satisfying childbirth experience. This article received the Helen I. Kelly award for best student article in Volume VIII, *Law & Inequality*.

1. *Skinner v. Railway Labor Executives' Ass'n*, 109 S. Ct. 1402, 1422 (1989) (Marshall, J., dissenting) (citations omitted). In *National Treasury Employees Union v. Von Raab*, 109 S. Ct. 1384 (1989), the Court held that railway workers and customs workers could be tested for drug use without individual suspicion or probable cause. Justice Scalia commented on urine testing in his dissent:

The Court agrees that this constitutes a search for purposes of the Fourth Amendment—and I think it obvious that it is a type of search particularly destructive of privacy and offensive to personal dignity.

... I decline to join the Court's opinion in the present case because neither frequency of use nor connection to harm is demonstrated or even likely. In my view the Customs Service rules are a kind of immolation of privacy and human dignity in symbolic opposition to drug use.

Id. at 1398 (Scalia, J., dissenting).

2. *Return of the Hard-Drug Menace*, U.S. News & World Rep., June 30, 1975, at 29 ("The federal 'war' on drugs, launched by President Nixon in 1969, combined a crackdown on drug traffickers with an expansion of facilities for treating addicts . . ."); Richard Cohen, *Users*, Washington Post, Dec. 26, 1982, at B1 ("[President Reagan], as we all know has declared war on drugs. . . . Of course, Richard Nixon did the same thing, as did Lyndon Johnson, and so did every president in memory."); Leonard Larsen, *'War on Drugs'—Here We Go*, Newsday, Aug. 25, 1989, at 78 ("With the nation crouched once more in the trenches, poised again to go over the top when President George Bush soon declares his own version of the war on drugs, there's time to reflect on the battle so far.")

with broadcast scenes of battle. Crack-house walls crushed by police-driven bulldozers, special force police kicking in apartment doors, anonymous suspects lying face down on the sidewalk—all have become almost routine television fare. Streets in some cities resound with echos of drug dealers' automatic weapons. Most of the civilian population observes this war with fear—fear of drug-users and fear of the crimes they commit to feed their addictions.³ Beyond fear, the body politic expresses increasing outrage at the social damage wrought by drug abuse and increasing anger at the abusers themselves.⁴

Against this background of increasing anger, an incident that occurred in the summer of 1989 galvanized public opinion in Minnesota. On August 5, a nurse at St. Paul's United Hospital found a patient, Gayle Turenne, injecting cocaine into her wrist either as she was giving birth or shortly afterward.⁵ The woman was later charged with and convicted of possession of cocaine and sentenced to a prison term of twenty-six months.⁶ The state's sentencing guidelines, however, called for only a probationary term for simple possession of cocaine.⁷ Judge James Campbell explained that the

3. *E.g.*, David Musto, *America's Forgotten Drug War*, Wilson Q., Summer 1989, at 59.

For years, the District of Columbia's chief of police, Major Sylvester, had been warning Congress . . . of cocaine's horrifying effects. "The cocaine habit is by far the greatest menace to society, because the victims are generally vicious. . . . The use of this drug predisposes [sic] [people] to commit criminal acts[.]" In 1909, President Theodore Roosevelt's Homes Commission presented the testimony of Sylvester and other officials to an alarmed Congress, which promptly restricted legal drug sales in the nation's capital.

Id. at 63-64.

4. See *infra* notes 10-11 and accompanying text for community reaction to one cocaine abuser.

5. Conrad deFiebre, *Harsh Sentence Imposed on Woman Who Injected Cocaine While Giving Birth*, Minneapolis Star Tribune, Oct. 20, 1989, at 1B, col. 1. Ramsey County District Judge James Campbell said Turenne's son was born prematurely with cocaine in his system. *Id.* Turenne denied using cocaine before the child's birth:

She pleaded guilty Aug. 31 to possession of the drug, but maintained that the syringe incident occurred after the child was born.

She also told authorities that the child was born prematurely because she had changed a tire on her car, not because of drug use. But she admitted inhaling cocaine while in labor.

Id. at 4B, col. 3.

6. *Id.* at 1B, col. 1.

7. Minnesota Sentencing Guidelines Commission, *Minnesota Sentencing Guidelines & Commentary IV* (rev. ed. 1988), reprinted in Minn. Stat. Ann. § 244 app. (West Supp. 1989). According to the sentencing guidelines, possession of cocaine under Minn. Stat. § 152.15 subd. 2(1) carries an offense severity of II. *Id.* at 398. The severity scale ranges from I, which includes possession of marijuana, to level X, which includes second degree murder with intent. See *id.* at 395-99. First degree murder is excluded from the guidelines. *Id.* at 396. If Turenne had no crim-

woman's crime justified the severity of the sentence because her act was "roughly akin to distributing cocaine in a schoolyard"⁸ and "[u]nlike most cocaine offenses, there was a victim in this case."⁹

Four days after the Turenne story broke, WCCO radio, the Twin Cities' AM giant, posed a related question on its state-wide, informal telephone survey: would listeners "support more government funding to battle cocaine addiction among pregnant women?"¹⁰ By the end of the approximately half-hour calling period, eighty-nine percent of the 143 individuals responding had voted "no" to more government funding.¹¹ Although the radio station makes no claims of scientific accuracy for any of its informal surveys, the overwhelmingly negative response suggests an emotion in the callers more basic than the instinct to pay lower taxes.

Later that fall, when the Turenne story was no longer front-

inal history, the presumptive sentence for her current offense would be a year and a day. *See id.* at 395. At the discretion of the judge, up to a year in jail and/or other non-jail sanctions can be imposed as conditions of probation. *Id.*

8. deFiebre, *supra* note 5, at 1B, col. 1.

9. *Id.*

10. Telephone interview with Steve Murphy, Morning News Editor at WCCO radio (Feb. 27, 1990). The station asked the question on August 9, 1989. Murphy states that the 143 callers during the half-hour phone-in period is an average number of callers. A columnist for the Minneapolis newspaper described the results of the WCCO radio survey and the anger directed toward Turenne personally.

The Good Neighbor's [WCCO] listeners weren't the only angry people. In a letter to [Judge] Campbell, Turenne wrote of the wrath that she was surrounded by, even in jail.

"... My mother received bad phone calls," Turenne wrote. "People drive by my house yelling terrible things. My life has been threatened countless times and now I'm sitting in the Ramsey County detention center with inmates that treat me as if I were dirt. . ."

Earlier this week Campbell said he was second-guessing himself almost from the moment he handed down the initial harsh sentence.

"It's tough to admit you goofed," said the 40-year-old judge . . .

Campbell is not naive. He knows that the statistics surrounding efforts to treat cocaine addicts "are dismal." He also knows, better than most, that drugs are tearing families and communities apart. His docket is full and the majority of the cases coming before him have a drug tie-in.

Doug Grow, *Judge Turns From Anger, Hoping to Help Addicted Mother*, Minneapolis Star Tribune, Nov. 10, 1989, at 1B col. 5.

Several months before Turenne gave birth, she had been convicted of drug possession. Officials of two counties, Dakota and Isanti, bickered over which county's funds would pay for the drug rehabilitation ordered by the judge in that case. *Id.* at 4B, col. 2. As a result, Turenne did not get the help she needed. Grow reported:

Campbell is not blaming either of the counties for their reluctance to pay the bills. "There is a financial crisis out there and there's a funding crisis for drug treatment," he said.

Still, the system had ordered Turenne to get treatment and then the system had failed to get her the treatment it said she needed.

Id.

11. Murphy, *supra* note 10.

page news, Judge Campbell reduced his original sentence to six months in the workhouse and five years of probation. He ordered also that Turenne attend Alcoholics Anonymous meetings during the probation.¹² "That a woman is injecting in the delivery room is outrageous," the judge said, but he had changed Turenne's sentence because "[i]t is also outrageous that a pregnant woman can't get treatment for an addiction."¹³ Judge Campbell's change in focus from his early anger at Gayle Turenne's act to his later showing of compassion for her, to his eventual directing of outrage toward the criminal justice and health care systems which denied her help, illustrate the difficulties inherent in finding a right answer to the problem of a single individual's drug abuse. Finding answers to an entire group's drug problem presents proportionately more difficulties.

Before the Turenne incident, Dr. Virginia Lupo, a resident physician at Hennepin County Medical Center, completed a study designed to assess the extent of drug use in the group to which Turenne belonged: women in labor and delivery. Between April 1, 1989 and June 30, 1989, Dr. Lupo conducted a test of 200 blinded urine samples from a group of 1800 women present in nine Minneapolis and St. Paul hospitals.¹⁴ The samples were tested for amphetamines, benzodiazepines, cannabis, barbiturates, and cocaine. The results of the tests showed no evidence of amphetamine use, but some presence of opiates and barbiturates. After eliminating the other drugs, Lupo found evidence of cocaine and cannabis in the urine samples in 2.9% and 7%, respectively.¹⁵

Because she observed in the course of her work evidence of drug abuse among pregnant women—evidence she later verified with her study—Dr. Lupo, along with the Hennepin County Attorney's Office, became instrumental in lobbying the Minnesota Legislature to pass what she calls a "darn good law."¹⁶ The result, popularly known as the "Crack Baby" bill, was passed as part of

12. Grow, *supra* note 10, at 1B, col. 5.

13. *Id.* at 4B, col. 1. Turenne was "expelled from her most recent cocaine treatment program . . . Oct. 2, after stealing from a hospital gift shop." deFiebre, *supra* note 5, at 1B, col. 2.

14. Virginia Lupo, "Born Addicted?" Symposium sponsored by Minnesota Medical Ass'n., Minnesota Hospital Ass'n., Brooklyn Park, Minnesota (Jan. 17, 1990).

15. *Id.* Dr. Lupo's data is as follows:

Hospitals	% cocaine	% cannabis
Public	7.3	13
Public/Private	1.0	4
Private	0.4	3

16. *Id.*

the Omnibus Crime Bill of 1989.¹⁷ Though the bill relates to many kinds of crime, Article Five of the bill specifically addresses "Prenatal Exposure to Certain Controlled Substances."¹⁸ The Article concerns the use of five named street drugs and substances listed in Schedules I, II, and III. The Schedules list hundreds of drugs which could potentially be abused—drugs with or without currently accepted medical uses in treatment.¹⁹ Among other things,

17. 1989 Minn. Laws ch. 290.

18. 1989 Minn. Laws ch. 290, Art. 5. This section, popularly known as the "Crack Baby" bill, was sponsored by Senator Ember Reichgott and Representative Kathy Blatz. A similar bill was introduced by Senator Jim Ramstad. Interested groups testifying in favor of passage were the Children's Defense Fund, Minnesota Department of Health, Minnesota Medical Association, and the Hennepin County Attorney's Office. Telephone interview with Dr. Lupo, Hennepin County Medical Center (Oct. 20, 1989).

19. Minn. Stat. § 152.02 (1988). The statute strikingly omits the most commonly abused chemical, alcohol, although the dangers that excessive use of alcohol poses to the developing fetus have been known to the scientific community since at least 1973. Ernest Abel, Fetal Alcohol Syndrome and Fetal Alcohol Effects 24 (1984) (citing P. Lemoine, H. Harousseau, J.P. Borteryu, J.C. Menuet, *Les enfants de parents alcooliques: Anomalies observées à propos de 127 cas.*, 21 *Ouest Médical* 476 (1968) (children born to alcoholic mothers showed distinctive pattern of anomalies); K. Jones, D. Smith, C. Ulleland, A. Streissguth, *Pattern of Malformation in Offspring of Chronic Alcoholic Mothers*, 1 *Lancet* 1267 (1973) (study brought fetal alcohol syndrome to international attention)). "Crack" and cocaine, on the other hand, have a relatively short history of abuse during this epidemic, and studies of children who were exposed prenatally are, of necessity, still being done. American College of Obstetricians and Gynecologists, Statement on Substance Abuse and Pregnancy before the Select Committee on Narcotics Abuse and Control, U.S. House of Representatives (Oct. 16, 1987). Dr. Lupo calls the omission of alcohol one "weakness of the law." Lupo, *supra* note 14. Legislative sponsors of the bill, however, either were not aware that alcohol poses a problem, or they believed that including a legal chemical on the list of substances would make the bill too controversial and therefore impossible to pass. Lupo, *supra* note 14 (comments of Sen. Reichgott and Rep. Blatz).

Although a state need not tackle every aspect of a problem, one might wonder why the statute does not cover alcohol. For a presentation of the detrimental effects of alcohol use during pregnancy, see Michael Dorris, *The Broken Cord* (1989). Dorris describes his struggle to raise an adopted child whose capacities for development were determined long before birth, after Adam was conceived and grown in an "ethanol bath." *Id.* at 264. Adam's symptoms include grand mal seizures, learning disabilities, and an inability to project future consequences from present actions. The author describes his son's inability to learn from experience: "He could not, cannot project himself into the future: 'If I do *x*, then *y* (good or bad) will follow.' . . . He existed in the present tense, with occasional reference to past precedent." *Id.* at 201.

Dorris believes that many of the mothers of Fetal Alcohol Syndrome children suffer from the syndrome themselves or from Fetal Alcohol Effect and are not able to associate their own heavy drinking with damage to their offspring: "I kept coming back to the obvious deduction that fetal alcohol victims were behaviorally among the most likely people to reproduce fetal alcohol victims. For them, logical argumentation had the least sway." *Id.* at 179. Dorris believes that such women, because they cannot connect their actions with consequences, are "impervious to

the bill orders the following changes in state law relating to pregnant women:

1. It amends the definition of "chemically dependent" under the civil commitment statute to include pregnant women who habitually and excessively use cocaine, heroin, phencyclidine (PCP), methamphetamine, or amphetamine "during the pregnancy";²⁰
2. It amends the definition of neglect in the child abuse statute to include prenatal exposure to a controlled substance, as evidenced by toxicology tests on mother and child at the time of delivery or developmental delays in the child's first year of life. Drugs included are from Schedules I, II, and III. The law also provides immunity from suit to medical personnel who administer the toxicology test without consent of the patient;²¹
3. It requires a pregnant woman's attending physician to conduct toxicology testing during prenatal care without consent "if the woman has obstetrical complications that are a medical indication"²² of possible use of Schedule I, II, and III drugs;²³

educational efforts." Interview with Michael Dorris, *Everyday Program* (NBC television broadcast, Oct. 27, 1989).

The Broken Cord contains an extensive bibliography on the subject of Fetal Alcohol Syndrome and Fetal Alcohol Effect. The book itself focuses on the problem of chronic alcohol abuse in the Native American population. See also Anastasia Shkilnyk, *A Poison Stronger Than Love: The Destruction of an Ojibwa Community* (1985). Shkilnyk writes about the cultural and genetic damage brought about by increasing alcohol use after a community's disruption:

At Grassy Narrows, the "catastrophic response" of women to the social and economic order of the new reserve is manifest in various ways. More than three-quarters of the women between the ages of thirty and fifty are very heavy drinkers. Only four of the thirty-three women in this age group are employed. The greatest incidence of child abandonment, neglect and child abuse is found among the families of women in their middle years. These women have stopped "caring for tomorrow." More important, in not caring for their own offspring, they have produced another generation of women who have no role models to follow in caring for their offspring.

Id. at 160-61. See also Thomas Mails with Dallas Chief Eagle, Fools Crow (1979) (a document of the life and times of Frank Fools Crow, medicine man of the Oglala tribe of Dakota Indians, born 1890-91). Fools Crow recounts the years between 1930 and 1940 at Pine Ridge, a time when he could foresee the dangers of alcohol:

Our family structure was crumbling because independence and irresponsibility were being encouraged among the young people. Bootleggers were after the Indian's money, and were hauling cheap wine and whiskey onto the reservation by the truckload. Our young men were being persuaded to sell liquor for them, and as a result it was not long before drunken people were trading every worthwhile thing they had for liquor. Even the young women were drinking now, and this assured a future tragedy of the worst possible proportions.

Id. at 148.

20. Minn. Stat. § 253B.02, subd. 2 (Supp. 1989).

21. Minn. Stat. § 626.5562, subd. 2(c) (Supp. 1989).

22. Minn. Stat. § 626.5562, subd. 1 (Supp. 1989).

23. Minn. Stat. § 626.5561, subd. 4 (Supp. 1989).

4. It mandates reporting of substance abuse by all those individuals required to report under the child abuse statute with the addition of the local welfare agency;²⁴
5. It requires the local welfare agency to offer services, including chemical dependency referrals for assessment or treatment and referrals for prenatal care, to the woman reported. The welfare agency may also act under the civil commitment statute, using emergency admission procedures if necessary. The commitment provisions are to take effect if the pregnant woman "refuses recommended voluntary services or fails recommended treatment."²⁵

One sponsor of the Crack Baby bill sees this law as a form of "preemptive strike" against forces ready and willing to pass laws punishing pregnant women for their addiction.²⁶ Dr. Lupo articulated the reasons for the law as she believes physicians see it. The "sentiment of the law," she said, is to "identify babies at risk of going to a home where drugs are being abused."²⁷ There is evidence that the Legislature did not share this sentiment.²⁸

The legislative intent may have been that this law deter future abuse or that it punish abusers. The bill originated not in the Committees on Health and Human Services, but in the Judiciary Committees of both houses of the Legislature. The provisions became part of the Omnibus Crime Bill, an act "relating to crime."²⁹ Notwithstanding its origins, if this is a public health law, what then would be the articulable state interest in this particular law? One state interest may be the conservation of medical resources. Babies with low birth weights, babies born prematurely, and children with disabilities require expensive, often long-term, care. Another state interest may be to protect the fetus. Were the health of the mother of primary concern, no need would arise for a separate classification for pregnant women under the civil commitment statute.

If the Legislature has expressed a state interest in conserving resources and protecting the fetus, the statute itself addresses the reach of the state in guarding those interests. First, the Legisla-

24. Minn. Stat. § 626.5561, subd. 1 (Supp. 1989). See Minn. Stat. § 253B.02, subd. 10 (Supp. 1989); Minn. Stat. § 626.556, subd. 3 (1988).

25. Minn. Stat. § 626.5561, subd. 2 (Supp. 1989).

26. Lupo, *supra* note 14 (comment of Rep. Kathy Blatz). Dr. Lupo mentioned United States Senator Pete Wilson of California, who believes pregnant women who use drugs should be sentenced to three years in prison. *Id.* (comment of Dr. Lupo). Representative Blatz said that she "always wanted the treatment." *Id.* (comment of Rep. Blatz).

27. *Id.*

28. See *infra* notes 29-37 and accompanying text.

29. 1989 Minn. Laws ch. 290.

ture authorized a "massive curtailment of liberty"³⁰ through the civil commitment process³¹ using a standard that applies only to pregnant women. Civil detention, whether intended as punishment or not, does punish women who fail to abstain from drugs. Whether the statute is nominally regulatory or criminal, the deprivation of the individual's liberty is the same.³² Second, a woman's personal physician must test for drug use during prenatal care; it is the responsibility of the physician, acting as an agent of the state, to decide if there is probable cause to test a urine sample.³³ Although the cost of the test will be included in the patient's bill for services,³⁴ the law requires that it be done without her consent. Medical personnel also must test both mother and child at birth,

30. Virginia Hiday, *Court Discretion: Application of the Dangerousness Standard in Civil Commitment*, 5 L. & Hum. Behavior 275, 276 (1981).

31. The Minnesota Commitment Act of 1982 defines "chemically dependent person" as:

any person (a) determined as being incapable of self-management or management of personal affairs by reason of the habitual and excessive use of alcohol or drugs; and (b) whose recent conduct as a result of habitual and excessive use of alcohol or drugs poses a substantial likelihood of physical harm to self or others as demonstrated by (i) a recent attempt or threat to physically harm self or others, (ii) evidence of recent serious physical problems, or (iii) a failure to obtain necessary food, clothing, shelter, or medical care.

Minn. Stat. § 253B.02, subd. 2 (1988).

Commitment proceedings, whether civil or criminal, are subject to both the equal protection clause and the due process clause of the fourteenth amendment. *Specht v. Patterson*, 386 U.S. 605 (1967).

The United States Supreme Court has not recognized pregnant women as a suspect class for purposes of equal protection analysis. In *Geduldig v. Aiello*, 417 U.S. 484 (1974), the Court held that a state disability insurance program did not discriminate invidiously against pregnant women by not providing benefits for disability caused by normal pregnancy. *Id.* at 497-98. The state was refusing to insure a particular risk, not the individuals who faced the risk. *Id.*

32. *But cf.* *United States v. Salerno*, 481 U.S. 739 (1987). In that case the Court stated: "The Bail Reform Act of 1984 . . . allows a federal court to detain an arrestee pending trial if the Government demonstrates by clear and convincing evidence after an adversary hearing that no release conditions 'will reasonably assure . . . the safety of any other person and the community.'" *Id.* at 741 (quoting 18 U.S.C. § 3142(e) (1982 & Supp. III)).

Chief Justice Rehnquist states in the majority opinion:

As an initial matter, the mere fact that a person is detained does not inexorably lead to the conclusion that the government has imposed punishment. To determine whether a restriction on liberty constitutes impermissible punishment or permissible regulation, we first look to legislative intent. Unless Congress expressly intended to impose punitive restrictions, the punitive/regulatory distinction turns on "whether an alternative purpose to which [the restriction] may rationally be connected is assignable for it, and whether it appears excessive in relation to the alternative purpose assigned [to it]."

Id. at 746-47 (citations omitted) (quoting *Kennedy v. Mendoza-Martinez*, 372 U.S. 144, 168-69 (1963)).

33. Minn. Stat. § 626.5562, subd. 1 (Supp. 1989).

34. Lupo, *supra* note 14 (comment of Sen. Donna Peterson).

again without consent, for purposes of showing prenatal child neglect.³⁵

Each of these statutory provisions implicitly presumes that fetal neglect and child neglect are one and the same. The persons mandated to report abuse are the same. For example, medical professionals, teachers, social workers, or volunteers must report suspected neglect to the police, the welfare agency, or the county sheriff.³⁶ A duty to report arises "if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy."³⁷ If the Legislature intended to recognize a duty to report at any time during the pregnancy, it has in essence pushed back the reach of the statute to the time of conception. Where lines will be drawn in the future and where in the present this statute fits into the medico-legal context remain unanswered questions. This essay addresses both.

Part I explores the informed consent doctrine as a baseline for the physician-patient relationship.³⁸ Related to informed consent is the judicial recognition of the patient's right of personal autonomy and the constitutional right of privacy. Part II discusses the growing trend toward non-consensual medical care for pregnant women.³⁹ Part III explores the rights of the fetus the law now recognizes and the possible consequences of recognizing fetal "personhood."⁴⁰ Part IV discusses the dangers to maternal freedom that changes in technology have caused.⁴¹ This essay concludes⁴² that in weighing the interests of the three competing claimants on the lives of pregnant women represented by the Crack Baby law—claims by law, medicine, and the individual woman—it is best in the end to give women "a quit-claim deed to

35. Minn. Stat. § 626.5562, subd. 2 (Supp. 1989) (mandating test of the newborn). Although there is some ambiguity about testing the mother at birth, the child neglect provision provides that both mother and child be tested:

"Neglect" includes prenatal exposure to a controlled substance, as defined in section 626.5561, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth

Minn. Stat. § 626.556, subd. 2(c) (Supp. 1989).

36. Minn. Stat. § 626.5561, subd. 1 (Supp. 1989). See Minn. Stat. § 626.556, subd. 3 (1988).

37. Minn. Stat. § 626.5561, subd. 1 (Supp. 1989).

38. See *infra* notes 44-75 and accompanying text.

39. See *infra* notes 76-154 and accompanying text.

40. See *infra* notes 155-201 and accompanying text.

41. See *infra* notes 203-228 and accompanying text.

42. See *infra* notes 229-239 and accompanying text.

themselves."⁴³

I. The Informed Consent Doctrine

The Legislature recognized that the Crack Baby law's testing requirements are a significant departure from the established doctrine of informed consent to medical treatment. To compensate, the Crack Baby law specifically provides immunity from liability for medical personnel who test women for evidence of drug abuse.⁴⁴ This section examines the reasons for the doctrine, some problems in its application, and finally the status of informed consent under Minnesota law.

The doctrine of informed consent demonstrates the common law's respect for individual autonomy. The right to personal space is a venerable tenet of the Anglo-American legal tradition.⁴⁵ Unconsented touching, whether harmful or offensive, may give rise to a legal cause of action.⁴⁶ Hostile intent on the part of the offender is not an element of the action; the gist of the tort is contact with the plaintiff's person without the plaintiff's consent.⁴⁷

As early as 1914, Justice Cardozo commented on unconsented touching in a suit for damages where the plaintiff had consented to a medical examination but had not consented to the surgery physicians performed while she was anesthetized.⁴⁸ Cardozo stated in dictum:

In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages. This is true, except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained.⁴⁹

The American Medical Association's current opinions on medical ethics⁵⁰ recognize the primacy of the right of an adult of sound mind to withhold or give consent to medical procedures and

43. Elizabeth Cady Stanton, *Address on the Divorce Bill*, in *An American Primer* 374 (Daniel Boorstin ed. 1966).

44. Minn. Stat. § 626.5562, subd. 4 (Supp. 1989).

45. William Prosser & W. Page Keeton, *Prosser & Keeton on the Law of Torts* § 9, at 39 (5th ed. 1984).

46. *Id.*

47. *Id.* at 40-41.

48. *Schloendorff v. Society of the N.Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914).

49. *Id.* at 129-30, 105 N.E. at 93 (citations omitted).

50. American Medical Association Council on Ethical and Judicial Affairs, *Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association* (1986) [hereinafter *Current Opinions*].

most states have codified the right.⁵¹ The Council on Ethical and Judicial Affairs of the American Medical Association spells out the informed consent doctrine, which includes the physician's duty to inform, and the patient's right to grant or withhold consent as well as the two exceptions to the rule: when a patient is unconscious or otherwise unable to consent, or when disclosing the risk poses a serious psychological threat to the patient.⁵² Section 8.07 of the Council's opinion states:

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his [or her] own determination on treatment. The physician's obligation is to represent the medical facts accurately to the patient or to the individual responsible for his [or her] care and to make recommendations for management in accordance with good medical practice. . . . Social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forego needed therapy. Rational informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing

51. *E.g.*, Minn. Stat. § 144.651 (1988) (the Minnesota Patient's Bill of Rights). A "patient" is "a person who is admitted to an inpatient facility for a period longer than 24 hours . . ." *Id.*, subd. 2. The Patient's Bill of Rights provides:

Subd. 9 - Information about treatment. Patients and residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the patients or residents can reasonably be expected to understand. . . . This information shall include the likely medical or major psychological results of the treatment and its alternatives. . . .

Subd. 12 - Right to refuse care. Competent patients and residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record.

Section 144.652 concerns violations of the patient's rights:

Subd. 2. Correction order; emergencies. A substantial violation of the rights of any patient or resident as defined in section 144.651, shall be grounds for issuance of a correction order pursuant to section 144.653 or 144A.10. The issuance or nonissuance of a correction order shall not preclude, diminish, enlarge, or otherwise alter private action by or on behalf of a patient or resident to enforce any unreasonable violation of the patient's or resident's rights. Compliance with the provisions of section 144.651 shall not be required whenever emergency conditions, as documented by the attending physician in a patient's medical record or a resident's care record, indicate immediate medical treatment, including but not limited to surgical procedures, is necessary and it is impossible or impractical to comply with the provisions of section 144.651 because delay would endanger the patient's or resident's life, health, or safety.

52. Current Opinions, *supra* note 50, at 32.

treatment.⁵³

One writer calls the informed consent doctrine "an unnatural graft onto medical practice" and an obligation "alien to medical thinking and practice."⁵⁴ In earlier times, the absence of a physician's legal duty to disclose may have been the result of a societal recognition that when there are few alternatives for treatment, the medical knowledge the patient and the physician possess may be more equal. The lack of an obligation to disclose may have risen from a long history of medical paternalism or the individual physician's urge, desire, and resolve to help other people.⁵⁵ The physician's resolve to help the patient who is already present in the office or hospital may, however, conflict with the patient's wish to be treated as a rational being capable of making informed decisions.

Two conflicting principles guide the discussion of informed consent: autonomy and beneficence.

The principle of autonomy declares that each person is in control of his own person, including his body and mind. This principle, in its purest form, presumes that no other person or social institution ought to intervene to overcome a decision made by a person about himself, whether or not that decision is "right" from any external perspective.⁵⁶

The assertive patient may believe that "my body's nobody's body but mine"⁵⁷ and come into conflict with the physician, who should by inclination and training be guided by the principle of beneficence.

[This principle] declares that what is best for each person should be accomplished. The principle incorporates both the negative obligation of nonmaleficence ("*primum non nocere*"—first of all, do no harm—the foundation of the Hippocratic oath) and the positive obligation to do that which is good. Thus, [physicians are obliged], under the principle of be-

53. *Id.*

54. Jay Katz, *The Silent World of Doctor and Patient* 1 (1984), quoted in Barry Furrow, Sandra Johnson, Timothy Jost & Robert Schwartz, *Health Law* 231 (1987) [hereinafter Furrow].

55. Richard Zaner, *Ethics and the Clinical Encounter* (1988). Zaner emphasizes the physician's resolve to help the patient:

Medical practice is guided by the moral resolve of physicians to put their knowledge, experience, time, and talents at the disposal of distressed or damaged persons, individually or as groups. *The resolve to help other people* (who are in need of help, ask for help, or are unable to help themselves) is governing: to interpret an afflicted person's presenting symptoms with the aim of attempting to correct, restore, or comfort, to the extent possible in particular circumstances.

Id. at 39 (emphasis in original).

56. Furrow, *supra* note 54, at 827.

57. Peter Alsop, *Draw the Line*, Flying Fish Record Co. (1979) (song lyric).

necience, to provide the highest quality of medical care for each of [their] patients.⁵⁸

The law currently recognizes autonomy as the first principle in medical decision-making and beneficence as the second.⁵⁹

The United States Supreme Court considered the question of patient autonomy in the context of a fourth amendment search and seizure case in which the police requested surgical removal of a bullet from a suspect's body.⁶⁰ The Court held that major surgery under anesthesia without consent is not a reasonable search.⁶¹ The Court noted that surgery done without a patient's consent "involves a virtually total divestment of [the individual's] ordinary control over surgical probing beneath his skin."⁶² Procedures involving a "slight intrusion," such as blood tests, do not present any constitutional problems for the Court if the police have established probable cause to arrest.⁶³

In 1976, the Minnesota Supreme Court considered the right of a committed, mentally-ill patient to reject some forms of medical treatment.⁶⁴ After discussing the "emerging right" of privacy under the United States Constitution and the Supreme Court's line of privacy cases, the Minnesota court concluded that intrusive forms of treatment may not be left to the discretion of medical personnel.⁶⁵ The court explained its understanding of the privacy right:

At the core of the privacy decisions, in our judgment, is the

58. Furrow, *supra* note 54, at 827.

59. *Id.*

60. *Winston v. Lee*, 470 U.S. 753 (1985).

61. *Id.* at 766.

62. *Id.* at 765. The Court stated:

When conducted with the consent of the patient, surgery requiring general anesthesia is not necessarily demeaning or intrusive. In such a case, the surgeon is carrying out the patient's own will concerning the patient's body and the patient's right to privacy is therefore preserved. In this case, however, . . . the Commonwealth proposes to take control of respondent's body, to "drug this citizen—not yet convicted of a criminal offense—with narcotics and barbiturates into a state of unconsciousness," and then to search beneath his skin for evidence of a crime. This kind of surgery involves a virtually total divestment of respondent's ordinary control over surgical probing beneath his skin.

Id. at 765 (quoting *Lee v. Winston*, 717 F.2d 888, 901 (4th Cir. 1983)).

63. *Breithaupt v. Abram*, 352 U.S. 432, 439 (1957) (upholding police taking a blood sample from an unconscious person after a fatal automobile accident because interest of society "in the scientific determination of intoxication" outweighed so "slight an intrusion" as a blood test); see also *Schmerber v. California*, 384 U.S. 757, 768 (1966) (holding that possibility of delay in getting blood test from driver suspected of driving while intoxicated justified police's taking blood sample as there "was plainly probable cause to arrest and charge [the suspect]").

64. *Price v. Sheppard*, 307 Minn. 250, 239 N.W.2d 905 (1976).

65. *Id.* at 262, 239 N.W.2d at 913.

concept of personal autonomy—the notion that the Constitution reserves to the individual, free of governmental intrusion, certain fundamental decisions about how he or she will conduct his or her life. Like other constitutional rights, however, this right is not an absolute one and must give way to certain interests of the state, the balance turning on the impact of the decision on the life of the individual. As the impact increases, so must the importance of the state's interest. . . .

But once justified, the extent of the state's intrusion is not unlimited. It must also appear that the means utilized to serve the state's interest are necessary and reasonable, or, in other words, in light of alternative means, the least intrusive.⁶⁶

The court went on to formulate a procedure which would serve the state's interest in providing health care for the committed patient and guard the patient's interest in making treatment decisions. The procedure requires three steps: 1) a petition submitted by the medical director of the mental health facility to the county court requesting an order authorizing treatment, 2) appointment of a guardian ad litem for the patient, and 3) an adversarial proceeding in which the court determines the necessity and reasonableness of the treatment.⁶⁷ The *Price* court excluded mild tranquilizers from the treatments requiring a court order, but it specifically included nonconsensual psychosurgery and electroshock as therapies requiring judicial approval.⁶⁸

The Minnesota Supreme Court declared in 1987 that the Minnesota Bill of Rights protects the same fundamental rights as the United States Constitution.⁶⁹ A year later the court came down on the side of personal autonomy for the committed mental patient.⁷⁰ The court declared in *Jarvis v. Levine*, that "[i]ndeed, the final decision to accept or reject a proposed medical procedure and its attendant risks is ultimately *not* a medical decision, but a personal choice."⁷¹

66. *Id.* at 257, 239 N.W.2d at 910.

67. *Id.* at 262, 239 N.W.2d at 910.

68. *Id.* at 263, 239 N.W.2d at 913.

69. *State v. Gray*, 413 N.W.2d 107, 111 (Minn. 1987). The court held that the Minnesota Bill of Rights protects the right of privacy, but no fundamental right exists under Minnesota Constitution to engage in sodomous acts for compensation. *Id.* at 114.

70. *Jarvis v. Levine*, 418 N.W.2d 139 (Minn. 1988).

71. *Id.* at 148. The court goes on to say:

The practice of the various professions has been vastly changed in the past quarter of a century. The public has been unwilling, quite properly, to allow professionals such as lawyers, doctors, dentists and others a completely free hand in handling either a client, customer or patient's case. Administering to a patient today may be more accurately described as a team effort on the part of both the doctor and the patient. It is a doctor's obligation to explain to the patient the diagno-

The plaintiff, Jarvis, still considered mentally ill and dangerous, was retained by the Minnesota Security Hospital at St. Peter after completing the sentence imposed for killing his sister.⁷² Jarvis refused treatment with psychotropic drugs which, he said, were not helpful to him and caused serious side effects.⁷³ In the *Jarvis* appeal, the court considered whether state medical personnel may administer neuroleptic medication, without prior court approval, in non-emergency situations to a committed patient who refuses consent. The court held that a committed mental patient, although not legally competent to make all decisions, may be competent to refuse consent to medical treatment and that the *Price* procedure must be followed in non-emergency situations.⁷⁴ The court explained that "[a]n institutionalized patient should have the same right [to refuse treatment] as one in a free and open society. To deny mentally ill individuals the opportunity to exercise that right is to deprive them of basic human dignity by denying their personal autonomy."⁷⁵

By requiring toxicological testing without the informed consent of the patient, the Minnesota Legislature has presented an ethical dilemma to medical personnel. They must, of course, obey the law, but in obeying that law they are treating pregnant women as incompetent persons with a lesser right to consent or withhold consent than held by committed, mentally-ill individuals. A law requiring that a woman be tested for drug use without informing her is even more disturbing when one views it in the context of an increasing trend of forced medical treatment after the pregnant woman has withheld consent.

II. Nonconsensual Medical Treatment for Pregnant Women

Nonconsensual medical treatment for pregnant women is becoming more common. This section examines the reasons for that trend and discusses the case law that attempts to define when such treatment may be ordered. When discussing nonconsensual medical treatment of pregnant women, commentators often use a "slippery slope" argument.⁷⁶ For example, in her discussion of court-

sis and proposed method of treatment. The informed patient then decides whether to consent to the treatment in whole or in part. The doctor may recommend, but does not dictate the final decision.

Id. at 148.

72. *Id.* at 140.

73. *Id.* at 141.

74. *Id.* at 147.

75. *Id.* at 148.

76. See Patrick Hurley, A Concise Introduction to Logic (1988). Hurley describes a slippery slope argument:

ordered Caesarean sections, Nancy Rhoden states:

Interventions such as brief involuntary hospitalization, testing, or surveillance to control drinking, drug use, diet, etc., may be viewed by some courts as less intrusive than major surgery—though longer lasting, such interventions are, after all, much less risky. Visions of a “slippery slope” progression appear very real when one begins with mandatory major surgery.⁷⁷

The slippery slope argument begins with evidence of court-ordered Caesarean sections for competent adult women.⁷⁸ Once nonconsensual major surgery receives documented medical and legal acceptance, other hypothetical steps on the slope lead to greater and earlier interventions. Where Minnesota's Crack Baby law lies on this hypothetical continuum is a matter for conjecture.

The reported cases, in which judges have considered and ratified medical decisions, fall into three areas: 1) blood transfusions,⁷⁹ 2) Caesarean sections,⁸⁰ and 3) other less physically invasive treatments.⁸¹ Until physicians and hospitals seek a court order, there is no way of knowing how frequently pregnant women are given treatment without their consent. Given the present legal climate, one would have to speculate that such incidents are infrequent.⁸²

The fallacy of slippery slope is a variety of the false cause fallacy. It occurs when the conclusion of an argument rests upon the claim that a certain event will set off a chain reaction, leading in the end to some undesirable consequence, yet there is not sufficient reason to think that the chain reaction will actually take place.

Id. at 128. Hurley also notes that the “[s]lippery slope is [a] fallacy that is sometimes difficult to evaluate. When the alleged chain reaction of events stretches the imagination, there is usually no problem. A problem arises when there is some likelihood that the chain reaction will actually occur.” *Id.* at 159.

77. Nancy Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 Cal. L. Rev. 1952, 2027 (1986).

78. See National Health Law Program, *Court-Ordered Cesareans: A Growing Concern for Indigent Women*, 21 Clearinghouse Rev. 1064, 1070 (1988) [hereinafter Nat'l Health Law Program].

79. *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, cert. denied, 377 U.S. 985 (1964).

80. *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 274 S.E.2d 457 (1981).

81. See *infra* notes 134-144 and accompanying text.

82. But see Rhoden, *supra* note 77: “Hospital personnel are increasingly contemplating a number of potentially involuntary treatments. I have participated in ethics rounds at several hospitals in which the issue was whether a pregnant patient whose conduct was in some way harmful to the fetus could be forcibly hospitalized and treated.” *Id.* at 207 n.384. See also Veronika Kolder, Janet Gallagher & Michael Parsons, *Court-Ordered Obstetrical Interventions*, 316 New Eng. J. Med. 1192 (1987). In 1986, the authors sent questionnaires to two groups of obstetricians: current heads of fellowship programs in maternal-fetal medicine and directors of maternal-fetal medicine divisions in residency programs in obstetrics and gynecology. Heads of fellowship programs, 57 total, responded in the following ways to questions posed by the authors: 46% thought that mothers who refused medical care and thereby endangered the fetus should be detained; 47% thought that court

If one accepts as a general rule the requirement that medical decisions for conscious, competent adults shall be made only with the consent of the patient, decisions made without that consent must come within some reasoned exception to the rule.

Judges who order medical treatment often use what is ostensibly a balancing test, balancing the woman's right of autonomy and privacy against the state's interest in the fetus.⁸³ In cases of objections to medical care for religious reasons, which are most often made by Jehovah's Witnesses, a first amendment right issue arises. A woman may refuse blood transfusions because she believes that they are the moral equivalent of drinking blood, a practice her religion forbids on biblical grounds.⁸⁴ A woman with different religious beliefs may refuse treatment because she places her trust in a spiritual power, not medicine.⁸⁵ The judicial re-

orders to protect a fetus should be extended to procedures such as intrauterine transfusions as these procedures become part of the medical standard of care; 26% advocated state surveillance of women in the third trimester who stay outside the hospital system. The percentage of respondents who consistently upheld a competent woman's right to refuse medical advice was 24%. *Id.* at 1193-94.

83. Rhoden, *supra* note 77, at 1998. Rhoden explores the ramifications of that balancing test:

A court that compels surgical delivery will undoubtedly phrase its discussion in terms of the rights of the woman and the state interest in the fetus. It may not think it is basing its decision on consequences, rather than simply balancing the woman's rights against the fetus's rights, or the state's interest in it. Yet, in an important sense its orientation is consequentialist; it is letting the dire consequences to the fetus "trump" the woman's rights of privacy, autonomy, and bodily integrity. Significantly, in contrast to state impositions to promote a larger and very public interest—the draft, for example—Cesarean cases are unique in that the rights of one individual are subordinated to protect another individual. The judicial decision to mandate such subordination, rather than to respect the woman's refusal of it, exemplifies the consequentialist view that when the outcome of respecting a right is very bad, the right can be overridden. The right-holder, then, is treated as a means to achieving the better consequences.

Id.

84. See Watch Tower Bible & Tract Society of Pennsylvania, *Life Everlasting in Freedom of the Sons of God* 321-43 (1966). The Jehovah's Witnesses' proscription against blood transfusions is based on both Old and New Testament scriptures and is conceptually related to their refusal to shed blood on the battlefield. The tract describes the rationale against blood transfusions:

Is It Cannibalism?

Today people in "civilized" lands shudder in horror at reports of cannibals drinking human blood in various parts of the world, but they take it as altogether different for themselves to receive transfusions of human blood into their physical systems. . . . His [Jesus Christ's] followers get the benefit of his shed blood, not by a blood transfusion, but by exercising faith in the value of his blood.

Id. at 337-39.

85. See, e.g., *Taft v. Taft*, 388 Mass. 331, 333, 446 N.E.2d 395, 396 (1983) ("[s]he believes that Jesus Christ will help her and is confident and convinced that no harm will come to her baby. She is sincere in her beliefs.").

sponse to such objections often follows a standard form: first, religious freedom is defined as freedom to believe and not always to act;⁸⁶ second, parents may not deny conventional medical care to their children because of their own religious beliefs;⁸⁷ therefore, a parent may not deny medical care to a fetus. Courts may also use *Roe v. Wade*⁸⁸ to justify decisions. If a woman has waived her constitutional right to an abortion and the fetus is viable, the reasoning goes, the state has a compelling interest in protecting her fetus. The court then may construe this interest to justify using force to overcome a woman's firmly held beliefs.⁸⁹

1. Court-Ordered Blood Transfusions

One 1964 state supreme court case is frequently cited as precedent for court-ordered blood transfusions. In *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*,⁹⁰ Williminia Anderson, a woman in her eighth month of pregnancy, began to hemorrhage and refused blood transfusions. The hospital sought a court order authorizing a transfusion without Mrs. Anderson's consent. The trial court held that the "judiciary could not thus intervene in the case of an adult or with respect to an unborn child."⁹¹ The New Jersey Supreme Court directed immediate arguments after the hospital appealed.⁹² Although Mrs. Anderson had already left the hospital against medical advice, the court heard arguments because the "parties request the court to determine the issues and since it is likely that the matter would arise again at the instance of an interested party . . ."⁹³ The court reversed the trial court's ruling and directed the lower court to appoint a guardian for the "infant," to substitute the guardian as party plaintiff, to order the guardian to consent to blood transfusions, and to direct the mother

86. See, e.g., *Cantwell v. Connecticut*, 310 U.S. 296, 303-04 (1940) ("[T]he [first amendment] embraces two concepts, freedom to believe and freedom to act. The first is absolute but, in the nature of things, the second cannot be. Conduct remains subject to regulation for the protection of society.").

87. See, e.g., *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944) ("Parents may be free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.").

88. 410 U.S. 113 (1973).

89. See, e.g., *In re A.C.*, 533 A.2d 611, 614 (D.C. 1987) ("the right of a woman to an abortion is different and distinct from her obligations to the fetus once she has decided not to timely terminate her pregnancy"); see also *infra* text accompanying notes 213-20.

90. 46 N.J. 421, 201 A.2d 537 (1964).

91. *Id.* at 423, 201 A.2d at 538.

92. *Id.*, 201 A.2d at 538.

93. *Id.*, 201 A.2d at 538.

to submit to blood transfusions. Finally, the supreme court ordered the trial court to "restrain the defendant husband from interfering therewith."⁹⁴ *Raleigh Fitkin* is cited frequently because it is a rare, published opinion concerning a court-ordered transfusion. More often orders for transfusions are given over the telephone and involve no published opinion.⁹⁵

2. Court-Ordered Caesarean Sections

Published opinions about nonconsensual Caesarean sections are equally rare. Evidence indicates that physicians in the United States are performing surgical deliveries at an increasing rate⁹⁶ and that the number of court-ordered procedures is rising as well. The likelihood that a woman may undergo a Caesarean section correlates to her socio-economic class.⁹⁷ One study suggests that the population undergoing the procedure is polarized:

[W]omen who have the highest incidence of Cesarean sections are those with the least and most education, lowest and highest incomes, the youngest and oldest ages, fewest and most pregnancies, those who have public insurance only or who carry the most comprehensive private insurance, those who have had no prenatal care at all and those who have had the most extensive care, and women who use general municipal hospitals and exclusive private hospitals.⁹⁸

94. *Id.* at 424, 201 A.2d at 538.

95. Nat'l Health Law Program, *supra* note 78, at 1064. New York courts delivered two frequently cited opinions in 1985. One case involved blood transfusions. *Crouse Irving Memorial Hosp., Inc. v. Paddock*, 127 Misc. 2d 101, 485 N.Y.S.2d 443 (Sup. Ct. 1985) (ordering pregnant woman to receive blood transfusions to protect welfare of fetus that was to be prematurely delivered). The second case involved appointing a physician as guardian for the fetus. *In re Jamaica Hosp.*, 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (Sup. Ct. 1985) (appointing physician as guardian of an 18-week-old fetus and ordering all that was necessary to save life of fetus, including administering blood transfusions over mother's objection).

96. See Paul Placek & Selma Taffel, *Recent Patterns in Cesarean Delivery in the United States*, 15 *Obstetrics & Gynecology Clinics of N. Am.* 607 (1988). The Caesarean rate in 1970 was 5.5 per 100 live births. In 1986 the rate was 24.1. *Id.* at 609. The authors found the 1986 rate per 100 live births at 27.1 for patients insured by Blue Cross, 20.8 for patients covered by Medicaid, and 18.7 for patients who were uninsured. *Id.* at 613. See also Metropolitan Life Ins. Co., *Cesarian Section in America: Dramatic Trends, 1970 to 1987*, Statistical Bull., Oct.-Dec. 1989, at 2. This bulletin shows an overall Caesarean section rate of 24.4 per 100 deliveries in 1987. Highest rates arose in the northeastern United States (26.4) and the South (25.5). The midwestern rate was 23.2 and the western rate was 22.5. *Id.* at 5.

Using figures from the National Center for Health Statistics (Public Health Service), compiled from 1965 to 1987, the bulletin projects a Caesarean section rate of approximately 35 per 100 births in 1995 and over 40 per 100 births in the year 2000. The statistics were gathered from non-federal, short-stay hospitals in the United States. *Id.* at 10.

97. See Kolder, Gallagher & Parsons, *supra* note 82, at 1195.

98. Nat'l Health Law Program, *supra* note 78, at 1065 (citing Helen Marieskind, *An Evaluation of Caesarean Section in the United States* (1979)).

When surgery is court-ordered, low-income and minority women are represented disproportionately. In one recent study of fifteen requested court orders, courts granted all but one.⁹⁹ Of the women concerned, 47% were black Americans, 33% were African or Asian, and 20% were white Americans.¹⁰⁰

The most frequently cited case which a hospital petitioned for a judicial order is *Jefferson v. Griffin Spalding County Hospital*.¹⁰¹ In that case Jessie Jefferson's physician diagnosed placenta previa in her thirty-ninth week of pregnancy.¹⁰² In placenta previa, the placenta literally "goes before" the fetus and covers the opening of the cervix, making vaginal delivery difficult and dangerous for both mother and child.¹⁰³ Ms. Jefferson's physician told her that she would require both a Caesarean section and possible blood transfusions.¹⁰⁴ She refused on religious grounds.¹⁰⁵ The hospital petitioned the trial court, which authorized the Caesarean section and any necessary blood transfusions "upon the defendant . . . in the event she presented herself to the hospital for delivery of her unborn child."¹⁰⁶ The court granted custody of the unborn child to the Georgia Department of Human Resources and the County Children's Services Department.¹⁰⁷ It granted power to the Children's Services Department to make all decisions regarding the birth of the child, including giving consent to surgical

99. Kolder, Gallagher & Parsons, *supra* note 82, at 1193. Among 21 requests for court-ordered intervention in obstetrical cases, orders were obtained in 86% of the cases. *Id.* Of those cases, 81% involved women who were black, Asian, or Hispanic, and 24% involved women who did not speak English as their primary language. *Id.* All were treated in a teaching hospital or were receiving public assistance. *Id.*

100. *Id.*

101. 247 Ga. 86, 274 S.E.2d 457 (1981).

102. *Id.* at 86, 274 S.E.2d at 458. Commentators favoring increased legal intervention in pregnancy have extensively quoted both the *Raleigh Fitkin* and the *Jefferson* cases. See, e.g., John Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 Va. L. Rev. 405 (1983). Robertson also alludes to the "slippery slope" argument:

These cases allow direct bodily intrusions to benefit a viable, full-term fetus when the risks that the intervention poses to the mother are reasonable. Although these cases involved saving both the fetus and the mother's life, they lay the foundation for requiring a pregnant woman to permit in utero fetal therapy essential to the health or survival of a viable fetus, so long as the therapy does not pose substantial threats to her life or health.

Id. at 445. For a discussion of the "slippery slope" argument, see *supra* notes 76-78 and accompanying text.

103. 247 Ga. at 86, 274 S.E.2d at 458.

104. *Id.*, 274 S.E.2d at 458.

105. *Id.*, 274 S.E.2d at 458.

106. *Id.*, 274 S.E.2d at 458.

107. *Id.* at 88, 274 S.E.2d at 459.

delivery.¹⁰⁸

The Georgia Supreme Court denied the Jeffersons a stay of the trial court's order.¹⁰⁹ A concurring justice wrote to express reservations about the power of the court to order a competent adult to submit to surgery, a power he described as "nonexistent" until this case.¹¹⁰ In affirming the trial court's order, the concurring justice explained: "we weighed the right of the mother to practice her religion . . . against her unborn child's right to live. We found in favor of her child's right to live."¹¹¹ Ms. Jefferson, as the woman in *Raleigh Fitkin*, delivered normally without surgery or transfusion, thus the court order was not carried out.¹¹²

The spectre of death haunts a more recent judicial opinion. In *In re A.C.*, Angela C. was twenty-five weeks pregnant and dying of cancer.¹¹³ While hospitalized at George Washington University, she agreed to treatment which might sustain her life until the twenty-eighth week of pregnancy, a time when her fetus would have a better chance of surviving a Caesarean delivery.¹¹⁴ When medical personnel believed Angela's death was imminent, the hospital sought a declaratory order from the District of Columbia Superior Court to determine whether the hospital could intervene in order to save the fetus.¹¹⁵ After a hearing at the hospital, the trial court allowed the physicians to operate.¹¹⁶ Earlier, after learning of the court's decision, Angela C. had consented to surgery, but she later withdrew her consent.¹¹⁷ Later the same day, following a telephone conference hearing, the appeals court denied the family's motion for a stay.¹¹⁸ The mother and child both died shortly after

108. *Id.*, 274 S.E.2d at 459.

109. *Id.* at 89, 274 S.E.2d at 460.

110. *Id.*, 274 S.E.2d at 460 (Hill, J., concurring). Justice Hill stated:

The power of a court to order a competent adult to submit to surgery is exceedingly limited. Indeed, until this unique case arose, I would have thought such power to be nonexistent. Research shows that the courts generally have held that a competent adult has the right to refuse necessary lifesaving surgery and medical treatment (i.e., has the right to die) where no state interest other than saving the life of the patient is involved.

Id., 274 S.E.2d at 460 (Hill, J., concurring).

111. *Id.* at 90, 274 S.E.2d at 460 (Hill, J., concurring).

112. George Annas, *The Impact of Medical Technology on the Pregnant Woman's Right to Privacy*, 13 Am. J.L. & Med. 213, 224 (1987).

113. *In re A.C.*, 533 A.2d 611 (D.C. 1987), *vacated*, 539 A.2d 203 (D.C. 1988), *rev'd*, 573 A.2d 1235 (D.C. 1990).

114. 533 A.2d at 612.

115. *Id.*

116. *Id.*

117. *Id.* at 613.

118. *Id.*

the surgery.¹¹⁹

In analyzing precedent, the trial court had cited an earlier, unreported District of Columbia case in which a court ordered a Caesarean section when physicians believed an abnormally long labor endangered the fetus.¹²⁰ The trial court ordered the hospital to take steps to "protect the birth and safety of the fetus," which the appeals court affirmed.¹²¹ The court also cited *Roe v. Wade* and stated that "as a matter of law, the right of a woman to an abortion is different and distinct from her obligations to the fetus once she has decided not to timely terminate her pregnancy."¹²² The court discussed the individual's right to bodily integrity and cited cases requiring parents to provide medical care for their children. The court came close to concluding that withholding treatment from a fetus is no different from withholding treatment from a child.¹²³ After considering the dangers inherent in a Caesarean section to a healthy woman, the death rate associated with Caesarean sections, and the specific interests of both Angela C. and her fetus, the court excluded the risk to the mother when balancing the interests since she had only a short time to live under any circumstances.¹²⁴

The court necessarily rendered its decision, albeit not its written opinion, in a very short period of time. Courts decide most re-

119. *Id.* at 612.

120. *Id.* at 613 n.1 (citing *In re Maydun*, 114 Daily Wash. L. Rptr. 2233 (D.C. Super. Ct. July 26, 1986) (affirmed by District of Columbia Court of Appeals by unreported order)).

121. *Id.* at 613 n.1.

122. *Id.* at 614.

123. *Id.* at 617.

124. *Id.* *Contra* Annas, *supra* note 112, at 225. George Annas discusses the court's statement that the Caesarean section would not significantly affect A.C.'s condition because she had at best two days of sedated life to live. Referring to the court's weighing of Angela C.'s interest in her life, Annas says:

[T]his reasoning will not do. It would, for example, permit the involuntary removal of vital organs prior to death if needed to "save a life." But if the child had already been born, it is unlikely that any court would compel the child's mother to undergo major surgery (e.g., a kidney donation) no matter how dire the potential consequences of refusal to the child. And no court would require the father of a child to undergo surgery, even to save the child's life. The ultimate rationale for the decision may be purely sexist: cesarean sections can never be done on males, and these male judges are simply unable to identify with the pregnant woman.

Annas, *supra* note 112, at 225. Annas has also observed that, "[t]he court actually wound up forcing Angela C. to have an abortion prior to her death, since her fetus was not viable." *Id.* at 225 n.59; see also Rhoden, *supra* note 77, at 1959 (discussing a singular case in which a woman's refusal to undergo a Caesarean section was upheld by a woman judge who had "an intuition that the delivery would turn out fine despite the doctors' dire predictions"); Nat'l Health Law Program, *supra* note 78, at 1065-68 (discussing legal flaws inherent in Caesarean section orders).

quests for court-ordered Caesarean sections under severe time constraints. The District of Columbia court stated that because of the time pressure and the court's lack of medical knowledge, such decisions would be better made by an administrative agency, with an opportunity for later judicial review.¹²⁵ The court failed to consider one other alternative: that the decision might be made by the woman and her family.

Finally, on appeal taken because the case was "capable of repetition, yet evading review,"¹²⁶ the Court of Appeals for the District of Columbia took a more positive view, emphasizing the woman's wishes and giving hope to women who suffer from conditions like that of Angela C. The court held that "a court must determine the patient's wishes by any means available, and must abide by those wishes unless there are truly extraordinary or compelling reasons to override them. When the patient is incompetent, or when the court is unable to determine competency, the substituted judgment procedure must be followed."¹²⁷ The court expanded on the concept of "substituted judgment," saying that if a once-competent patient is no longer able to render an informed decision, the court must make a substituted judgment on behalf of the patient based on all the evidence.¹²⁸ "[T]he court as decision-maker must 'substitute itself as nearly as may be for the incompetent, and . . . act upon the same motives and consideration as would have moved her. . . .'"¹²⁹

In two cases heard by trial courts, pregnant women made decisions with their feet. A brief account of the facts of these cases raises visions of malevolent slavers pursuing Eliza and her baby across the Ohio River's icy floes. In a Michigan case, when a woman objected to a Caesarean section on religious grounds, the court authorized the police to find her and transport her to the

125. 533 A.2d at 612. The court stated:

Complex issues—legal, moral and religious—are presented, and courts, though they must under present circumstances, are often hard pressed to arrive at a right answer. The courts do, however, make the final mortal decision. This is, in itself, probably the best that can be said of the process. It would be far better if, by legislation, these bio-ethical decisions could be made by duly constituted and informed ethical groups within the health care system, and if desired, appellate review as provided in other administrative proceedings. In this way, the need to attempt to inform judges of, to them, complex medical facts on very short notice would be eliminated.

Id.

126. 573 A.2d 1235, 1242 (D.C. 1990).

127. *Id.* at 1247.

128. *Id.* at 1249.

129. *Id.* (quoting *City Bank Farmers Trust Co. v. McGowan*, 323 U.S. 594, 599 (1945)).

hospital against her will.¹³⁰ She went into hiding and later gave birth normally at another hospital.¹³¹ In a New York case, a woman purposefully travelled across town for her prenatal care because the hospital she chose had a reputation of restraint in interfering with normal delivery processes.¹³² After her physician diagnosed hypertension and preeclampsia and obtained a court order for surgery, the woman successfully delivered at home with the assistance of a midwife.¹³³

3. Other Nonconsensual Medical Care

In a 1983 Massachusetts case, a husband, rather than a physician or hospital, requested the court to order medical care.¹³⁴ During Susan Taft's fourth month of pregnancy, her husband, Lawrence, brought a *pro se* action requesting that the court force his wife to undergo a surgical "purse string" operation to overcome the problem of an incompetent cervix.¹³⁵ Ms. Taft had undergone the procedure with three previous children.¹³⁶ After a religious conversion, however, she decided to trust in Jesus Christ rather than surgeons.¹³⁷ The trial court ruled that the commonwealth had an interest which justified overriding the woman's right to free exercise of religion.¹³⁸ The state's interest, the court said, is "a fundamental and traditional interest in the physical and mental health of all parents, their children already born and their unborn children."¹³⁹

The appeals court reversed, finding that the medical circumstances were not so compelling as to justify curtailing Ms. Taft's privacy and first amendment rights.¹⁴⁰ The court noted the uncertain medical prognosis and the age of the fetus. "No case has been cited to us," the court said, "nor have we found one, in which a court ordered a pregnant woman to submit to a surgical procedure in order to assist in carrying a child not then viable to term."¹⁴¹

Although the Supreme Judicial Court of Massachusetts re-

130. Rhoden, *supra* note 77, at 2004. (citing *In re Baby Jeffries*, No. 14004, slip op. at 9 (Jackson County, Mich. Probate Ct. May 24, 1982)).

131. *Id.* at 2004 n.272 (citing Detroit Free Press, June 16, 1982, at 3A, col. 4).

132. Rhoden, *supra* note 77, at 2028 n.389 (citing North Central Bronx Hosp. v. Headley, No. 1992-85 (N.Y. Sup. Ct. Jan. 6, 1986)).

133. *Id.* at 2028; see also *id.* at 2012 n.292.

134. Taft v. Taft, 388 Mass. 331, 446 N.E.2d 395 (1983).

135. *Id.* at 332, 446 N.E.2d at 396.

136. *Id.*, 446 N.E.2d at 396.

137. *Id.* at 333, 446 N.E.2d at 396.

138. *Id.*, 446 N.E.2d at 396.

139. *Id.*, 446 N.E.2d at 396.

140. *Id.* at 334, 446 N.E.2d at 397.

141. *Id.* at n.4, 446 N.E.2d at 397 n.4.

fused to order Susan Taft to submit to surgery, lower courts elsewhere have not exercised the same restraint in ordering medical care—care which some might view as less physically intrusive than forced major surgery. In California, a mother was convicted of child endangerment for keeping two children on a macrobiotic diet which had damaged the younger child.¹⁴² The appeals court, finding the lower court's order that the mother not become pregnant too restrictive, approved intensive monitoring of her diet if she became pregnant again.¹⁴³ A Michigan appeals court required a pregnant diabetic to take insulin in spite of religious objections.¹⁴⁴ Monitoring medication and diet, although less physically intrusive than surgery or a transfusion, requires close supervision for an extended period of time. Policing a woman's behavior throughout pregnancy requires an intrusion at least as great, if not greater, than one-time surgery.

When pregnancy is not a factor, the law does not require one person to submit to surgery to aid another, even with an overwhelming public interest in the preservation of individual life.¹⁴⁵ A Pennsylvania court wrote a seething opinion when one cousin suffering from aplastic anemia sought an order to compel another cousin to donate bone marrow to treat his disease.¹⁴⁶ The court viewed the cousin's refusal to donate morally indefensible, but would not legally compel him to donate.¹⁴⁷ The court discussed our society's respect for the individual as its first principle:

For a society which respects the rights of *one* individual, to sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for *another* member, is revolting to our hard-wrought concepts of jurisprudence. Forceable extraction of living body tissue causes revulsion to the judicial mind. Such would raise the spectre of the swastika and the Inquisition, reminiscent of the horrors this

142. *People v. Pointer*, 151 Cal. App. 3d 1128, 199 Cal. Rptr. 357 (1984).

143. *Id.*

144. Rhoden, *supra* note 77, at 1954 n.15 (citing *In re Unborn Baby Wilson*, No. 81-108 AV (Mich. Ct. App. Mar. 9, 1981)).

145. Lawrence Nelson, Brian Buggy & Carol Weil, *Forced Medical Treatment of Pregnant Women: "Compelling Each to Live as Seems Good to the Rest"*, 37 Hastings L.J. 703, 756 (1986).

There is a "public interest" in protecting every person in need of aid and preserving his life that is "precisely analogous to the public interest in saving the fetus," yet we do not force other potential Samaritans to render aid. It would be utterly anomalous to rely on the state or public interest to preserve the fetus' life in the situation of a woman refusing medical treatment and yet ignore it in other situations.

Id. (quoting Donald Regan, *Rewriting Roe v. Wade*, 77 Mich. L. Rev. 1569, 1607 (1979)).

146. *McFall v. Shimp*, 10 Pa. D. & C.3d 90 (1978).

147. *Id.*

portends.¹⁴⁸

The law will not mandate organ donations from one person to another, nor will it require donations from cadavers in order to benefit the lives of those waiting for transplants.¹⁴⁹ Thus, the family of a deceased person can deny body parts that could benefit several persons.¹⁵⁰ What hierarchy of values are the courts reflecting when they order surgery on pregnant women but not on corpses?

Courts often consider risks to the pregnant woman when deciding whether to order surgery. If the court decides it is reasonable for the woman to assume the risks, an assessment most likely based on evidence presented by medical personnel, it may order the woman to take that risk. When courts force pregnant women to undergo medical care that exposes them to any degree of risk, the legal system is imposing a duty required of no other person. "Parents have a duty to rescue their children—i.e., to be basic Good Samaritans—but they have no duty to be 'Splendid Samaritans,' embarking upon rescues that risk their life or health."¹⁵¹

The coerciveness of court-ordered medical care raises one last question: how much force are the medical profession and the legal system prepared to use to enforce these court orders? Whether a woman quietly bows to a court's order, is forcibly anesthetized in the hospital,¹⁵² or hides from the police,¹⁵³ the process injects an

148. *Id.* at 92 (emphasis in original).

149. Lawrence Nelson & Nancy Milliken, *Compelled Medical Treatment of Pregnant Women: Life, Liberty, and Law in Conflict*, 259 J. A.M.A. 1060, 1065 (1988).

The American Council on Transplantation estimates that of more than 23,000 potential cadaver organ donors available yearly, only 3,000 (about 13%) actually become donors. We see no good reason why pregnant women should be treated with less respect than corpses. In fact, it seems bizarre that many persons should die for want of a vital organ that could be taken from a corpse, while a living pregnant woman can be forced to undergo major surgery that exposes her to a not insubstantial risk of harm or death.

Id. at 1065. *But see* Strunk v. Strunk, 445 S.W.2d 145 (Ky. 1969) (ordering a kidney transplant from "mentally defective" man to his brother due in part to the donor's emotional dependence on his brother).

150. See Nelson & Milliken, *supra* note 149, at 1065.

151. Nancy Rhoden, *Cesareans and Samaritans*, 15 Law, Med. & Health Care 118, 121 (1987) (using Judith Jarvis Thomson's well-known "Splendid Samaritan" term).

152. See Nat'l Health Law Program, *supra* note 78, at 1068 (citing Ronna Jurov & Richard Paul, *Cesarean Delivery for Fetal Distress Without Maternal Consent*, 63 Obstetrics & Gynecology 596 (1984)).

In a case arising at the Los Angeles County/USC Medical Center, the judicial time frame was even shorter—in fact, it was nonexistent. When the fetus of a 20-year-old, unmarried woman with no prenatal care began to demonstrate an irregular heartbeat during labor, the doctors informed the mother that a Cesarean was necessary for her welfare and for that of the fetus. Although the woman refused the procedure, the doctors ignored her continued protest and performed

unseemly element of overt or covert violence into the physician-patient relationship. Medical personnel may achieve immediate goals by using courts to gain permission to force certain treatment and they may avoid later liability,¹⁵⁴ but at what cost? The long-term result to a relationship ideally between allies can only be mistrust. This mistrust may lead women who most desperately need the support and advice of a physician to seek the least prenatal care.

III. Fetal Rights Now Recognized by Law

Legal intervention injects an atmosphere of antipathy into the physician-patient relationship. Moreover, such intervention ultimately may make the maternal-fetal relationship an adversarial one.

The Crack Baby law presents the issue of whether a fetus has a legal right to be free of the dangers of maternal drug use or if fetal health should be a social norm enforced in other ways. At this time the law recognizes fetal rights selectively, primarily in the law of property and tort.¹⁵⁵

Early common law limited recognition of rights of the unborn to the right to inherit property, that is, the right of the heir in utero to receive its share of a decedent's property.¹⁵⁶ Blackstone wrote in 1762 that an "infant in its mother's womb" is considered a person for purposes of inheritance.¹⁵⁷

the emergency surgery. The physicians reported that "no force was necessary" to anesthetize the patient.

Id.

153. See *supra* note 130 and accompanying text.

154. Liability appears to have been a concern in *In re A.C.*, 533 A.2d 611 (D.C. 1987). The court stated:

The hospital had sought a declaratory order whether to intervene with surgery given the mother's last-minute objection, an objection for which there may have been one or more reasons. There were physicians willing to operate and staff able to care for the fetus as needed. With the competing legal interests of the mother (some of which would survive her, e.g., D.C. Code § 16-2701 (1981)) and those of the fetus or child, it is understandable why the hospital sought before-the-fact judicial pronouncement of its duties.

Id. at 617 (citation omitted).

155. Robert Chabon, *The Legal Status of the Unborn Child*, J. Legal Med., May 1977, at 22 (citing 2 William Blackstone, Commentaries *130 (1762)).

156. *Id.*

157. John Cribbet, *Principles of the Law of Property* 87 (2d ed. 1975) (quoting 2 William Blackstone, Commentaries *130 (1762)). Cribbet explains "the eagerness with which the first heir was awaited, even by men with few of the normal fatherly characteristics":

Blackstone demonstrates the learning on the subject. "The issue must be born alive. Some have had a notion that it must be heard to cry; but that is a mistake. Crying indeed is the strongest evidence of its be-

Recovery in tort for injuries sustained before birth, a more recent legal development, is generally contingent upon live birth.¹⁵⁸ Before 1946, courts in the United States did not recognize a right to recover for injuries inflicted before birth, even for a live-born child.¹⁵⁹ In 1884, the Massachusetts Supreme Judicial Court, in an opinion written by Justice Holmes, denied recovery for prenatal injury resulting in death of the fetus after the mother slipped and fell on a negligently maintained road.¹⁶⁰ The court denied recovery because no precedent existed in the common law.¹⁶¹ The child, the court added, was still part of the mother and if there were damages to be recovered, they are recoverable by the mother, not the child.¹⁶²

Sixteen years after Holmes's opinion, the Illinois Supreme Court denied recovery to a child injured as a result of injury to the mother while she awaited birth in the hospital.¹⁶³ The often-quoted dissent in this case foreshadowed a change in the law. In his dissenting opinion, Justice Boggs observed:

Medical science and skill and experience have demonstrated that at a period of gestation in advance of the period of parturition the fetus is capable of independent and separate life, and that though within the body of the mother it is not merely a part of her body, for her body may die in all of its parts and the child remain alive and capable of maintaining life when separated from the dead body of the mother.¹⁶⁴

Justice Boggs's thoughts were echoed in a majority opinion decades later. In 1946, the District Court for the District of Columbia decided *Bonbrest v. Kotz*,¹⁶⁵ in which it held that an injured child could bring an action to recover for prenatal injuries sustained during birth.¹⁶⁶ This change in the law quickly spread

ing born alive; but it is not the only evidence. The issue also must be born during the life of the mother; for, if the mother dies in labour, and the Caesarean operation is performed, the husband in this case shall not be tenant by the curtesy: because, at the instant of the mother's death, he was not clearly entitled, as having had no issue born, but the land descended to the child, while he was yet in his mother's womb; and the estate, being once vested, shall not afterwards be taken from him."

Id. at 87 (quoting 2 William Blackstone, Commentaries *127-28).

158. Prosser & Keeton, *supra* note 45, § 55 at 368.

159. *Id.*

160. Dietrich v. Inhabitants of Northampton, 138 Mass. 14 (1884).

161. *Id.*

162. *Id.* at 17.

163. Allaire v. St. Luke's Hosp., 184 Ill. 359, 56 N.E. 638 (1900).

164. *Id.* at 370, 56 N.E. at 641 (Boggs, J., dissenting).

165. 65 F. Supp. 138 (D.D.C. 1946).

166. *Id.*

throughout the country.¹⁶⁷ The majority in *Bonbrest* said that considering the viable child as part of its mother is a "contradiction in terms. . . . Modern medicine is replete with cases of living children being taken from [their] dead mothers."¹⁶⁸ The living child now may maintain an action against third parties for the consequences of prenatal injuries.¹⁶⁹ In some jurisdictions this cause of action may be limited to a fetus capable of independent life at the time of injury¹⁷⁰ or, alternatively, to a fetus who is "quick."¹⁷¹ The fetus also may have a cause of action for wrongful death in some jurisdictions.¹⁷² Here the cause of action passes on to the estate's personal representative.¹⁷³

In one case, the Illinois Supreme Court held that a child could bring an action for a negligent act which took place eight years before she was conceived.¹⁷⁴ Physicians had transfused the mother, who had Rh-negative blood, with Rh-positive blood and had not disclosed the mistake.¹⁷⁵ When the young woman's antibodies later caused disease in her fetus, the court held that the plaintiff's existence was a foreseeable event and allowed the child to recover for her injuries.¹⁷⁶

Tort recovery for injuries to the fetus is normally limited to the liability of third parties.¹⁷⁷ American courts in the nineteenth century adopted a rule which allowed no actions between a parent and a minor child for intentional or negligent torts.¹⁷⁸ The parental immunity doctrine is based on the belief that legal actions between a parent and child would not only disturb family peace, but also interfere with the parents' role as disciplinarians of the child.¹⁷⁹

One Michigan case, involving a plaintiff's discolored teeth, chipped away at the foundations of the parental immunity doc-

167. Prosser & Keeton, *supra* note 45, § 55, at 368.

168. *Bonbrest*, 65 F. Supp. at 140.

169. Prosser & Keeton, *supra* note 45, § 55, at 368.

170. *Id.* at 368-69.

171. *Id.* "Quick" means the mother is "able to feel the fetal movements." Dorland's Illustrated Medical Dictionary 1401 (27th ed. 1988). "Quickening" refers to the first recognizable movements of the fetus (recognizable to the mother), appearing usually from the sixteenth to the eighteenth week of pregnancy. *Id.*

172. Note, Tort Recovery for the Unborn Child, 15 J. Fam. L. 277, 283-85 (1976-77).

173. *Id.*

174. *Renslow v. Mennonite Hosp.*, 67 Ill. 2d 348, 357, 367 N.E.2d 1250, 1255 (1977).

175. *Id.* at 349, 367 N.E.2d at 1251.

176. *Id.* at 357, 367 N.E.2d at 1255.

177. Prosser & Keeton, *supra* note 45, § 122, at 904-05.

178. *Id.* § 122, at 904.

179. *Id.* § 122, at 905.

trine. In *Grodin v. Grodin*,¹⁸⁰ the mother took the antibiotic tetracycline early in pregnancy, a time when the drug can discolor developing tooth enamel in the fetus. The child's attorney found facts supporting a claim of negligence against the mother. After discovering that the mother's homeowner's policy insured against tort liability, the attorney named both her and her attending physician as defendants.¹⁸¹ The child charged the mother with negligent failure to get a pregnancy test at the proper time and negligent failure to inform her doctor that she was taking tetracycline.¹⁸² The court found that the child had a cause of action against her mother and held that the mother had a duty to act with "reasonable exercise of parental discretion."¹⁸³

Recently, the Illinois Supreme Court overturned a decision in which the appellate court restricted the parental immunity doctrine in order to allow a parent-child tort action.¹⁸⁴ In a case in which the plaintiff child alleged prenatal damage caused by the mother's negligence in driving her car, the lower court held that the parental immunity doctrine should not be applied to defeat the child's cause of action in negligence against the mother.¹⁸⁵ In reversing, the supreme court observed:

There are far-reaching issues of public policy inherent in the question whether to recognize a cause of action in tort for maternal prenatal negligence. Judicial scrutiny into the day-to-day lives of pregnant women would involve an unprecedented intrusion into the privacy and autonomy of the citizens of this State.¹⁸⁶

After holding that no cause of action would lie for maternal prenatal negligence, the court emphasized that the opinion in "no way minimize[s] the public policy favoring healthy newborns. Preg-

180. 102 Mich. App. 396, 301 N.W.2d 869 (1980).

181. *Id.* at 398, 301 N.W.2d at 870. But for an insurance policy, the mother in *Grodin* would not have been named a defendant:

During discovery the physician claimed that he had warned the mother to stop taking tetracycline. To guard against the possibility that the jury might ascribe the child's injury to the mother and refuse to award damages, the attorney advised amending the complaint to include the mother as a defendant, because a homeowner's policy insured the mother against tort liability. But for the existence of a homeowner's insurance policy with broad coverage, the suit against the mother would not have been filed.

Robertson, *supra* note 102, at 441 n.114.

182. *Grodin*, 102 Mich. App. at 398, 301 N.W.2d at 870.

183. *Id.* at 400, 301 N.W.2d at 870 (quoting *Plumley v. Klein*, 388 Mich. 1, 8, 199 N.W.2d 169, 179 (1972)).

184. *Stallman v. Youngquist*, 129 Ill. App. 3d 859, 473 N.E.2d 400 (1984), *rev'd*, 125 Ill. 2d 267, 531 N.E.2d 355 (1988).

185. *Stallman v. Youngquist*, 129 Ill. App. 3d 859, 473 N.E.2d 400 (1984).

186. 125 Ill. 2d at 279-80, 531 N.E.2d at 361.

nant women need access to information about the risks inherent in everyday living on a developing fetus"187

Whatever one's religious or philosophical beliefs about the personhood of the fetus, legal recognition is limited. Extending legal rights of the fetus—particularly recognition as a person under the fourteenth amendment to the Constitution—could cause far-reaching and untoward consequences. David Westfall, a professor of law at Harvard, discusses some of the possible effects of constitutional personhood for fetuses in an article in which he considers human life amendments introduced in Congress.¹⁸⁸ Westfall infers that most of the amendments were introduced in reaction to dictum in *Roe v. Wade*¹⁸⁹ in which the Court stated that if fetuses were persons within the meaning of the fourteenth amendment, their "right to life would then be guaranteed specifically by the Amendment."¹⁹⁰ An amendment guaranteeing personhood from conception could lead to several adverse results:

1. *Congressional Elections* - The fourteenth amendment requires that congressional representatives be apportioned according to the "whole number of persons in each State."¹⁹¹ "Persons" for purposes of apportionment include many individuals who are not allowed to vote.¹⁹² If a fetus is a legal person, women at any stage of pregnancy could be counted twice for census purposes—presumably three or more times for multiple gestations.

2. *Federal Income Tax* - Deductions for dependents are within the power of Congress. If Congress allowed deductions for fetuses as well as for children, tax benefits could theoretically cover two

187. *Id.* at 280, 531 N.E.2d at 361.

188. David Westfall, *Beyond Abortion: The Potential Reach of a Human Life Amendment*, 8 Am. J. L. & Med. 97 (1982). Various human life amendments were introduced during the 97th Congress. Westfall uses the term "conceptus" to avoid value-laden terminology. He considers the extent of the rights of the fetus under the proposed constitutional amendments.

If a conceptus is to be considered a "person" for purposes of the fourteenth amendment, courts will have to determine the extent of its rights. At least three alternative approaches could be followed: (1) the only right of the conceptus is protection from destruction by abortion; (2) the conceptus enjoys protection from any form of bodily injury to the same extent as other persons, but no protection of property rights or other non-bodily interests; and (3) the conceptus enjoys the same rights as other persons, subject to legislative authority to adopt reasonable classifications of persons.

Id. at 103.

189. 410 U.S. 113 (1973).

190. *Id.* at 156-57.

191. U.S. Const. amend XIV, § 2.

192. Westfall, *supra* note 188, at 108.

years of taxable income, whether or not a live birth occurs.¹⁹³ This could lead to a tax savings for an inexpensively maintained dependent. Such tax savings, Westfall wryly notes, could be used to fund a trip to a country where abortion is legal.¹⁹⁴

3. *Inheritance* - Live birth has been a requirement for inheritance under the common law since at least 1830.¹⁹⁵ Recognition of fetal personhood would require a change in that rule of law. Under a typical lapse statute, a fetus would be considered issue surviving a deceased father.¹⁹⁶ The mother would then inherit by intestacy if the fetus dies after the father. Under a typical intestacy statute, if a father is survived by a wife, a child, and a fetus, and the fetus later miscarried, the mother would be heir to two one-third shares of her husband's estate.¹⁹⁷ The live child would then receive less than its due share of the father's estate.

4. *Gender-based Employment Discrimination* - More fertile women could be excluded by employers from certain jobs on fetal protection grounds rather than to protect the woman herself.¹⁹⁸

5. *Administrative Problems* - Granting fetuses personhood would require administrative resources. Since not all pregnancies end in a live birth, it is not possible to keep track of the number of fetuses by counting births and subtracting forty weeks. It would be necessary to charge an agency with the responsibility of keeping track of the fetal population. The government would have to record the names and addresses of pregnant women along with respective dates of conception.¹⁹⁹ Absent some form of voluntary reporting by women, perhaps those interested in income tax deductions, this would require massive governmental intrusion into daily lives.

6. *Child Abuse and Neglect Statutes* - Such statutes would be applicable from the date of conception. A woman could face legal consequences for her actions even before she knows she is pregnant. After she is visibly pregnant she would risk being reported

193. *Id.* at 112.

194. *Id.*

195. *Id.* at 128.

196. *See id.* at 128-29.

197. *Id.* at 129. "Thus an incentive would be created for women to assert that they were pregnant with the conceptus of an intestate decedent when he died, and that the conceptus did not miscarry until after his death." *Id.*

198. This form of discrimination exists now. *See Note, The Evolution of the Right to Privacy After Roe v. Wade*, 13 Am. J. L. & Med. 493, 521-24 (1987); *see also Note, Title VII and Exclusionary Employment Practices: Fertile and Pregnant Women Need Not Apply*, 17 Rutgers L.J. 95, 122-23 (1985).

199. *See Westfall, supra* note 188, at 132-33.

to the local welfare agency or police department by persons mandated to report by statute or those who "voluntarily report" as under the Minnesota child abuse statute.²⁰⁰

7. *Changes in Medical Care* - Recognizing a fetus as a "person" from the time of conception could greatly affect choices in medical care. Methods of birth control which prevent implantation after fertilization such as intrauterine devices and "morning-after" pills could be banned.²⁰¹ Early surgical intervention to increase the margin of safety for the woman in the case of tubal or ectopic pregnancies or in situations where spontaneous miscarriage is imminent could leave physicians liable for fetal homicide.²⁰² Moreover, if the health of the woman and the fetus are of equal concern, would a woman suffering from cancer have to forego chemotherapy or radiation therapy until she either miscarries or gives birth? Conversely, the woman may no longer be able to refuse drugs and therapies benefitting the fetus but not the woman.

IV. Line-Drawing as Technology Advances

Might the precedent set by the Crack Baby law lead to more governmental monitoring of pregnant women in the future? Until a relatively short time ago, medicine had no way to monitor pregnancy and legal institutions had no will. The law was concerned merely with reproduction to the extent of forbidding abortion—and in some states contraception—and to condoning forced sterilization of "defectives." "The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes," Justice Holmes noted in *Buck v. Bell* because "three generations of

200. See *id.* at 117. Westfall also addresses a pregnant woman's simple freedom to move about:

The interests of the conceptus will often diverge from those of the woman From the standpoint of the conceptus, a passive carrier who exposes it to the minimum risk of miscarriage or prenatal injury is preferred. She should not smoke, drink, or use any drugs with possible adverse effects on the conceptus. Coffee may be interdicted. Skiing, working in hazardous environments, flying, and riding in automobiles might be prohibited for such women in order to minimize possible adverse effects on the conceptus. Indeed, the Victorian regime for upper-class pregnant women that minimizes activities either inside or outside the home might be ideal. Restricting the activities of potentially pregnant women might similarly be justified on the ground that such classification is necessary to protect the conceptus during the period between conception and proof of pregnancy.

Id. at 110-11.

201. *Id.* at 117.

202. George Ryan, Jr., *Medical Implications of Bestowing Personhood on the Unborn*, in *Defining Human Life: Medical, Legal, and Ethical Implications* 84, 85-86 (Margery Shaw & A. Edward Doudera eds. 1983).

imbeciles are enough."²⁰³ Now, however, the courts are significantly involved in reproductive issues, beginning with the striking down of a statute prohibiting distribution of contraceptives to married people in *Griswold v. Connecticut*.²⁰⁴

Advances in medical knowledge can be used to enhance or to limit the liberty rights of women. George Annas, a professor of law at Boston University, sees *Griswold* and *Roe v. Wade*²⁰⁵ as situations in which the court used medical advances to enhance the liberty rights of women.²⁰⁶ In the forced-Caesarean cases, on the other hand, he sees "the potential dark side of technology":²⁰⁷

Here medical advances, including ultrasound, fetal monitoring, safer cesarean sections, and neonatal intensive care units were used not to enhance the rights of pregnant women, but instead to provide an excuse to ignore them, by concentrating exclusively on the potential child. The lesson these cases teach is that technology untempered by human rights can lead to brutal dehumanization of pregnant women.²⁰⁸

What constitutes appropriate obstetrical care is necessarily a fluid concept.²⁰⁹ In fact, the use of existing technology can change the medical standard of care. If most physicians routinely use fetal monitors during labor, for example, the physician who does not use a monitor may be exposed to increased risk of liability.²¹⁰

203. *Buck v. Bell*, 274 U.S. 200, 207 (1927) (citing *Jacobsen v. Massachusetts*, 197 U.S. 11 (1904)).

204. 381 U.S. 479 (1965).

205. 410 U.S. 113 (1973).

206. Annas, *supra* note 112, at 216-18.

207. *Id.* at 226.

208. *Id.*

209. See Richard Wertz & Dorothy Wertz, *Lying-In: A History of Childbirth in America* 29-73 (1977). The authors trace the history of childbirth practices in Europe before the settlement of the American colonies through the "natural" childbirth movement in the 1970s. They discuss, among other things, the puerperal fever iatropidemic and Oliver Wendell Holmes's writing on the subject; "Twilight Sleep" labor and delivery using the hallucinogenic drug scopolamine; and some rather perverted hospital-centered practices during the 1940s and 1950s. They end their book with a plea for not only good, but the best, prenatal and obstetrical care for women of all economic circumstances.

210. If there is an iatropidemic of Caesarean sections taking place, it may be caused in part by a perceived epidemic of litigation. Alexander Capron discusses the influence of fetal monitoring on the Caesarean section rate:

If fetal monitoring is used inappropriately—for example, if it goes from being a screening technique used to warn of possible danger to being substituted for physicians' and nurses' clinical judgment—unnecessary operations may occur, resulting in needless harm to women during labor. Yet once a technique such as EFM [Electronic Fetal Monitoring] has been widely adopted it is very difficult for a physician in a litigation-conscious world to resist using it even if statistically it is likely to cause more net harm, especially when the harm spreads out in relatively small increments over a large population while the harm avoided would fall dramatically on a few people.

Some legal academicians would impose a duty of care on the woman to the point where she would function as little more than a "fetal container" once she became pregnant.²¹¹

The woman's duty of care would include submitting to a variety of tests and procedures to ensure the best possible outcome for the fetus in light of current or future technology. The advocates of the technological imperative ("if it can be invented, it must be used") are troubled by the trimester analysis of *Roe v. Wade*.²¹² To overcome the argument that a woman has a right to privacy in early pregnancy, the writers find an implied waiver of that right once a woman passes that variable point in pregnancy where the fetus is viable. Some examples of their views are:

- Conflicts over management of the pregnancy arise only after [the woman] has decided to become or remain pregnant. Once she decides to forgo abortion and the state chooses to protect the fetus, the woman loses the liberty to act in ways that would adversely affect the fetus.²¹³
- When a woman has chosen not to obtain an abortion, the state should be able to assert its right to prohibit conduct likely to result in injury *in utero*.²¹⁴
- It will take courage to reverse the well-established legal presumption that the mother's rights transcend those of the fetus. This presumption should hold only if the fetus does not become a living child.²¹⁵

Those who promote active state protection of the fetus after a woman's "waiver" of abortion do not dwell on the fact that many wo-

Alexander Capron, *Tort Liability in Genetic Counseling*, 79 Colum. L. Rev. 618, 668-69 (1979); accord Jane McCusker, Donald Harris & David Hosmer, Jr., *Association of Electronic Fetal Monitoring During Labor with Cesarean Section Rate and with Neonatal Morbidity and Mortality*, 78 Am. J. Pub. Health 1170, 1173 (1988) (concluding that "EFM has contributed to increasing cesarean section rate in this country Although some evidence supports benefits of EFM to high-risk pregnancies, the bulk of the evidence from studies of lower-risk pregnancies . . . provide[s] little evidence of benefit"). Compare Kirkwood Shy, David Luthy, Forrest Bennett, Michael Whitfield, Eric Larson, Gerald van Belle, James Hughes, Judith Wilson & Morton Stenchever, *Effects of Electronic Fetal-Heart-Rate Monitoring, as Compared with Periodic Auscultation, on the Neurological Development of Premature Infants*, 322 New Eng. J. Med. 588, 593 (1990) ("The study suggests that clinicians should be attentive to potentially adverse outcomes associated with [EFM]. . . . [A]s compared with a structured protocol of periodic fetal auscultation, [EFM] did not improve the neurologic development of children born prematurely.").

211. George Annas, *Pregnant Women as Fetal Containers*, Hastings Center Rep., Dec. 1986, at 13.

212. 410 U.S. 113 (1973).

213. Robertson, *supra* note 102, at 437.

214. Note, *Maternal Substance Abuse: The Need to Provide Legal Protection for the Fetus*, 60 S. Cal. L. Rev. 1209, 1223 (1987).

215. Margery Shaw, *Conditional Prospective Rights of the Fetus*, 5 J. Legal Med. 63, 95 (1984).

men, for reasons of ethics or religion, would not consider aborting under any circumstances. Many women "waive" their right to abortion because they live in rural areas with no abortion facilities or because they have no money to pay for the procedure. Loss of liberty is the penalty for those women who remain pregnant, whatever their reasons.

After "waiving" her right to privacy, some fetal rights advocates would require that the pregnant woman submit to medical interventions that might aid the fetus.²¹⁶ John Robertson, a professor of law at the University of Texas, would have a pregnant woman submit to surgery on the fetus in utero:

The fact that the mother must undergo surgery as part of the fetal therapy procedure would be no defense if the procedure did not present an undue risk to her life or health. She waived her right to resist bodily intrusions made for the sake of the fetus when she chose to continue pregnancy.

The more difficult question would be whether the therapy could be directly imposed on her against her will. Would her interest in bodily integrity override the unborn child's interest in life and health? Bodily intrusions for the sake of another are highly disfavored, but are not unknown to the law. If the risk to the mother is slight and the benefit to the child is great, there are precedents that would authorize a court to order treatment against the mother's will. . . .

. . . .
. . . Once the fetus reaches viability and the mother no longer has the right to abort, more intrusive or risky interventions could be justified.²¹⁷

Robertson then cites the *Raleigh-Fitkin*²¹⁸ transfusion case and the *Jefferson*²¹⁹ Caesarean section cases as precedents for forced treatment. He would make a mother's refusal of fetal therapy the basis for civil suit or criminal prosecution if her refusal "resulted in death or injury to the fetus."²²⁰

John E.B. Myers, professor of law at McGeorge, University of the Pacific, urges that courts construe existing child abuse statutes to include the fetus:

Recent years have witnessed remarkable advances in prenatal medicine and fetal surgery. As medical science achieves greater ability to treat unborn children, demand for such care will grow. At the same time, cases will occur where parents

216. Robertson, *supra* note 102, at 444, 447.

217. *Id.* at 444-45, 447.

218. *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964).

219. *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 274 S.E.2d 457 (1981).

220. Robertson, *supra* note 102, at 444.

unjustifiably refuse to consent to care. Interpreting child abuse and neglect statutes to include the unborn will enable courts to override parental objection in appropriate cases. In an age when medicine can treat and cure the unborn child, society will not tolerate a complete vacuum of authority to provide care in compelling cases.²²¹

Margery Shaw, professor of medical genetics and community medicine at the University of Texas, recommends testing pregnant women for substance abuse and ordering confinement if necessary.

An analogy to fetal abuse would suggest that health care professionals and others could be required, by properly drawn statutes, to report both *potential* and *actual* fetal abuse. Furthermore, such statutes could give the courts broad authority to compel parents and prospective parents to enter alcohol and drug abuse rehabilitation programs, and, in the extreme, to take "custody" of the fetus to prevent mental and physical harm.²²²

Jeffrey Parness, professor of law at Northern Illinois University, advocates confinement of pregnant substance abusers. Since he has a strong interest in preventing handicaps, he would also mandate genetic testing:

There is also an arguable case for state custody of both males and females of childbearing age for the purpose of conducting genetic tests geared to providing information about the prospective [sic] of preventable handicaps—particularly where the tests are not very intrusive and where the means of prevention are available and easily employed.²²³

Parness believes that a genetic test with negative implications and "[r]ecognition of an unborn's interest in not being born with severe handicaps could thus be encouraged by state financial support of the prospective parent's desire to abort."²²⁴ State support could also be used for amniocentesis or surgery leading to sterility.²²⁵

Shaw would add legal penalties for those parents who choose not to abort if they learn of a potential defect in the fetus through genetic testing.²²⁶

[A]s reproductive alternatives proliferate, parents may face the option of refraining from ordinary conception and childbirth, utilizing methods to circumvent abuse to their prospective

221. John Myers, *Abuse and Neglect of the Unborn: Can the State Intervene?*, 23 Duq. L. Rev. 1, 30-31 (1984). Among other procedures, Meyers mentions chorionic villus biopsy, which could permit diagnosis of certain fetal abnormalities as early as the sixth week of pregnancy. *Id.* at 30 n.141.

222. Shaw, *supra* note 215, at 100.

223. Jeffrey Parness, *The Duty to Prevent Handicaps: Laws Promoting the Prevention of Handicaps to Newborns*, 5 W. New Eng. L. Rev. 431, 461 (1983).

224. *Id.* at 462.

225. *Id.*

226. Shaw, *supra* note 215, at 111.

children, remaining childless, or facing civil or criminal charges if they negligently or purposefully bring defective fetuses to term when, by reasonable behavior, they could have avoided such a tragedy.²²⁷

Writers of the Robertson-Shaw ilk are persuasive writers in influential positions who would use a monstrous medical-state apparatus as a means to utopian ends. But their means are unrealistic in a society that values individual liberty. Justice Blackmun observed that Supreme Court cases have long "recognized that the Constitution embodies a promise that a certain private sphere of individual liberty will be kept largely beyond the reach of government. . . . That promise extends to women as well as to men."²²⁸ The condition of pregnancy should not alter this promise.

V. Conclusion

The Crack Baby law appears at a time when the medical and legal communities are both more able and more willing than ever before to interfere with a pregnant woman's right to self-management. The law broods at the crossroads of ability and will and proceeds with the purported purpose of doing "something" about the problem of prenatal substance abuse.²²⁹ Looking at this purpose in a purely utilitarian light leads one to ask how much exactly of the pregnant woman's freedom the state is prepared to sacrifice for questionable benefits.

If the state interest in this law is promoting the health of the fetus, driving women away from medical care until delivery is imminent is not going to achieve that end. If the state interest in this law is conservation of resources—resources that damaged children may require after birth—the statute and the accompanying appropriations arrive with too little too late. If the state interest is in punishment or if the law is designed as a safety valve to release some of the voters' anger, the Legislature may have achieved that end.

Three requirements of the Crack Baby law may be discouraging women who are most at-risk of complicated pregnancies from seeking prenatal care.

First, the civil commitment provision is being used. As of March 1, 1990, four women from Hennepin County were involuntarily committed and waited for delivery in a locked ward located

227. *Id.* at 100.

228. *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 772 (1986).

229. Lupo, *supra* note 14 (comment of Rep. Kathy Blatz).

in a Twin Cities teaching hospital.²³⁰ They are receiving treatment.

Second, until the Legislature makes technical amendments, reports of prenatal substance abuse must be made to the police.²³¹

Third, nonconsensual drug testing continues. It was the Legislature's original intention, as understood by the bill's sponsors, that a woman not be informed by her physician that her urine will be tested for drugs and that she not be informed of what the consequences of a positive test will be for her.²³²

The law mandates drug treatment for pregnant women other than those who are civilly committed, but the Legislature provided less than one million dollars for the counties to do so.²³³ Three treatment facilities funded by the Department of Health are located in the urban areas of Minneapolis and St. Cloud.²³⁴ Karen Ganley, director of one of these programs, Eden Day in Minneapolis, sees two problems with the Crack Baby reporting law. She says there are only about thirty-five treatment beds in the state that can accommodate women with children, and because women fear losing their children, they are getting even less prenatal care.²³⁵

230. Telephone interview with Evelyn Lund, Hennepin County Probate Court (Feb. 27, 1990).

231. Lupo, *supra* note 14. Sponsors of the bill indicated that they plan to fine-tune the law in the next legislative session. *Id.* Technical amendments may include the following changes:

1. an elimination of the requirement that prenatal substance abuse be reported to the police;
2. a clarification of the number of drugs listed. Schedules I, II, and III consist of hundreds of drugs, including marijuana and prescription drugs. The law was not aimed at use of marijuana, the sponsors say, and the law should be changed to restrict the mandated reporting to the five street drugs: cocaine, heroin, PCP, amphetamine, methamphetamine;
3. a clarification of the physician's duty to test and report without consent of the patient. There may be a conflict with the Data Practices Act, and the Legislature intended that the woman being tested *not* be informed.

Non-technical amendments may include the addition of alcohol to the reporting requirement.

Id. Senator Ember Reichgott, the Senate sponsor of the bill, believes that the commitment provisions of this statute will be challenged on due process grounds. *Id.*

232. *Id.* (comments of Rep. Kathy Blatz).

233. *Id.*

234. The facilities are: Turning Point and Eden Day in Minneapolis, Minnesota and Journey Home in St. Cloud, Minnesota. These are pilot projects to provide treatment for pregnant women or women with children. Telephone interview with Pam Young, Minnesota Dep't of Health and Human Serv., St. Paul, Minnesota (Jan. 2, 1990).

235. Daniel Anderson, *Drug Program Treats Mother but Doesn't Take Away Her Baby*, Minneapolis Star Tribune, Apr. 24, 1990, at 2E, col. 3.

Without prenatal care, there can be no early intervention to treat a woman's addiction. Drugs and alcohol can have detrimental effects on the developing fetus even before the woman knows that she is pregnant. One study on cocaine use published in the *Journal of the American Medical Association* found that neurobehavioral deficiencies were present in infants who were exposed to cocaine during the first trimester of pregnancy only.²³⁶ The authors of the study conclude that early intervention in pregnancy can result in "improved obstetric and neonatal outcome"²³⁷ but that prevention and education programs are imperative in order to reach all women of childbearing age.²³⁸

The Crack Baby law mandates educational programs in the public schools, aimed particularly at those who may be at high risk of pregnancy coupled with controlled substance or alcohol use.²³⁹ Mass education about the dangers of chemical use during pregnancy and mass education concerning the needs for birth control for those who are addicted may in the end be the only state action which does not threaten the personal autonomy and privacy of any woman who becomes pregnant.

The dangers inherent in the Crack Baby law go beyond the context of illegal or controlled drug abuse. The legislators have set a precedent for state intervention in the lives of pregnant women which may in the future weave a trap that will entangle all women—not just women exposed by necessity to the social welfare

236. Ira Chasnoff, Dan Griffith, Scott MacGregor, Kathryn Dirkes & Kayreen Burns, *Temporal Patterns of Cocaine Use in Pregnancy: Perinatal Outcome*, 261 J. A.M.A. 1741 (1989).

237. *Id.* at 1744.

238. *Id.*

239. Minn. Stat. § 121.883 (Supp. 1989).

Program for Public Education Regarding the Effects of Controlled Substance and Alcohol Use During Pregnancy.

Subdivision 1. Public education regarding the effects of controlled substance and alcohol use during pregnancy. The commissioner of education, in consultation with the commissioner of health, shall assist school districts in development and implementing programs to prevent and reduce the risk of harm to unborn children exposed to controlled substance and alcohol use by their mother during pregnancy. Each district program must, at a minimum:

- (1) use planning materials guidelines, and other technically accurate and updated information;
- (2) maintain a comprehensive, technically accurate, and updated curriculum;
- (3) be directed at adolescents, especially those who may be at high risk of pregnancy coupled with controlled substance or alcohol use;
- (4) provide in-service training for appropriate district staff; and
- (5) collaborate with appropriate state and local agencies and organizations.

Id.

system—but judges, physicians, or the governor herself. Are these times now so urgent that constitutional rights are truly too extravagant to endure?

STATUTORY APPENDIX

1989 Minn. Laws Ch. 290, Art. 5

"An Act relating to crime - H.F. No. 59

Additions in text are indicated by underline; deletions by ~~strike-outs~~. Sec. 2 Minnesota Statutes 1988, section 253B.02, subdivision 2, is amended to read:

SUBD. 2. CHEMICALLY DEPENDENT PERSON. "Chemically dependent person" means any person (a) determined as being incapable of self-management or management of personal affairs by reason of the habitual and excessive use of alcohol or drugs, and (b) whose recent conduct as a result of habitual and excessive use of alcohol or drugs poses a substantial likelihood of physical harm to self or others as demonstrated by (i) a recent attempt of threat to physically harm self or others, (ii) evidence of recent serious physical problems, or (iii) a failure to obtain necessary food, clothing, shelter, or medical care.

"Chemically dependent person" also means a pregnant woman who has engaged during the pregnancy in habitual or excessive use, for a nonmedical purpose, of any of the following controlled substances or their derivatives: cocaine, heroin, phencyclidine [PCP], methamphetamine, or amphetamine.

Sec. 3 Minnesota Statutes 1988, section 253B.02, subdivision 10, is amended to read:

SUBD. 10. INTERESTED PERSON. "Interested person" means an adult, including but not limited to, a public official, including a local welfare agency acting under section 5, and the legal guardian, spouse, parent, legal counsel, adult child, next of kin, or other person designated by a proposed patient.

Sec. 4 Minnesota Statutes 1988, section 626.556, subdivision 2, is amended to read:

SUBD. 2. DEFINITIONS. As used in this section, the following terms have the meanings given them unless the specific content indicates otherwise:

(c) "Neglect" means failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter or medical care when reasonably able to do so or failure to protect a child from conditions or actions which imminently and seriously endanger the child's physical or mental health when reasonably able to do so. Nothing in this section shall be construed to (1) mean that a child is neglected solely because the child's parent,

guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child, or (2) impose upon persons, not otherwise legally responsible for providing a child with necessary food, clothing, shelter, or medical care, a duty to provide that care. "Neglect" includes prenatal exposure to a controlled substance, as defined in section 5, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, or medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance. Neglect also means "medical neglect" as defined in section 260.015. subdivision 10 2a, clause (e) (5).

Sec. 5 626.5561 REPORTING OF PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES.

SUBDIVISION 1. REPORTS REQUIRED. A person mandated to report under section 626.556, subdivision 3, shall immediately report to the local welfare agency if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy. Any person may make a voluntary report if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy.

SUBD. 2. LOCAL WELFARE AGENCY. If the report alleges a pregnant woman's use of a controlled substance for a nonmedical purpose, the local welfare agency shall immediately conduct an appropriate assessment and offer services indicated under the circumstances. Services offered may include, but are not limited to, a referral for chemical dependency assessment, a referral for chemical dependency treatment if recommended, and a referral for prenatal care. The local welfare agency may also take any appropriate action under chapter 253B, including seeking an emergency admission under 253B.05. The local welfare agency shall seek an emergency admission under section 253B.05 if the pregnant woman refuses recommended voluntary services or fails recommended treatment.

SUBD. 3. RELATED PROVISIONS. Reports under this section are governed by section 626.556, subdivisions 4, 4a, 5, 6, 7, 8, and 11.

SUBD. 4. CONTROLLED SUBSTANCES. For purposes of this section and section 6, "controlled substances" means a controlled substance classified in schedule I, II, or III under chapter 152.

Sec. 6. 626.5562 TOXICOLOGY TESTS REQUIRED.

SUBDIVISION 1. TEST; REPORT. A physician shall administer a toxicology test to a pregnant woman under the physician's care to determine whether there is evidence that she has ingested a controlled substance, if the woman has obstetrical complications that are a medical indication of possible use of a controlled substance for a nonmedical purpose. If the test results are positive, the physician shall report the results under section 5. A negative test result does not eliminate the obligation to report under section 5, if other evidence gives the physician reason to believe the patient has used a controlled substance for a nonmedical purpose.

SUBD. 2. NEWBORNS. A physician shall administer to each newborn infant born under the physician's care a toxicology test to determine whether there is evidence of prenatal exposure to a controlled substance, if the physician has reason to believe based on a medical assessment of the mother or the infant that the mother used a controlled substance for a nonmedical purpose prior to the birth. If the test results are positive, the physician shall report the results as neglect under section 626.556. A negative test result does not eliminate the obligation to report under section 626.556 if other medical evidence of prenatal exposure to a controlled substance is present.

SUBD. 3. REPORT TO DEPARTMENT OF HEALTH. Physicians shall report to the department of health the results of tests performed under subdivisions 1 and 2. A report shall be made on February 1 and August 1 of each year, beginning February 1, 1990. The reports are medical data under section 13.41.

SUBD. 4. IMMUNITY FROM LIABILITY. Any physician or other medical personnel administering a toxicology test to determine the presence of a controlled substance in a pregnant woman or in a child at birth or during the first month of life is immune from civil or criminal liability arising from administration of the test, if the physician ordering the test believes in good faith that the test is required under this section and the test is administered in accordance with an established protocol and reasonable medical practice.

SUBD. 5. RELIABILITY OF TESTS. A positive test result reported under this section must be obtained from a confirmatory test performed by a drug testing laboratory licensed by the department of health. The confirmatory test must meet the standards established under section 181.953, subdivision 1, and the rules adopted under it.

Minn. Stat. § 253B.05 (1988)

EMERGENCY ADMISSION

SUBDIVISION 1. EMERGENCY HOLD. Any person may be admitted or held for emergency care and treatment in a treatment facility with the consent of the head of the treatment facility upon a written statement by an examiner that: (1) he has examined the person not more than 15 days prior to admission, (2) he is of the opinion, for stated reasons, that the person is mentally ill, mentally retarded or chemically dependent, and is in imminent danger of causing injury to himself or others if not immediately restrained, and (3) an order of the court cannot be obtained in time to prevent the anticipated injury.

The statement shall be: (1) sufficient authority for a peace or health officer to transport a patient to a treatment facility, (2) stated in behavioral terms and not in conclusory language, and (3) of sufficient specificity to provide an adequate record for review. A copy of the statement shall be personally served on the person immediately upon admission. A copy of the statement shall be maintained by the treatment facility.

SUBD. 3 DURATION OF HOLD. Any person held pursuant to this section may be held up to 72 hours, exclusive of Saturdays, Sundays, and legal holidays, after admission unless a petition for the commitment of the person has been filed in the probate court of the county of the person's residence or of the county in which the facility is located and the court issues an order pursuant to section 253B.07, subdivision 6. [§ 253B.07, Subd. 6, Apprehend and hold orders.]

§ 253B.02 DEFINITIONS

SUBD. 7 EXAMINER. "Examiner" means a licensed physician or a licensed consulting psychologist, knowledgeable, trained and practicing in the diagnosis and treatment of the alleged impairment.

§ 626.556 REPORTING OF MALTREATMENT OF MINORS

SUBD. 3. PERSONS MANDATED TO REPORT. A professional or his delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological and psychiatric treatment, child care, education, or law enforcement who has knowledge of or reasonable cause to believe a child is being neglected or physically or sexually abused shall immediately report

the information to the local welfare agency, police department or the county sheriff. [. . .]

Any person not required to report under the provisions of this subdivision may voluntarily report to the local welfare agency, police department or the county sheriff if he has knowledge of or reasonable cause to believe a child is being neglected or subjected to physical or sexual abuse. [. . .]

Minn. Stat. § 152.02 (1988)

SCHEDULES OF CONTROLLED SUBSTANCES; ADMINISTRATION OF CHAPTER

Subdivision 1. There are established five schedules of controlled substances, to be known as Schedules I, II, III, IV, and V. Such schedules shall initially consist of the substances listed in this section by whatever official name, common or usual name, chemical name, or trade name designated.

Subd. 7. The board of pharmacy is authorized to regulate and define additional substances which contain quantities of a substance possessing abuse potential in accordance with the following criteria:

(1) The board of pharmacy shall place a substance in Schedule I if it finds that the substance has: A high potential for abuse, no currently accepted medical use in the United States, and a lack of accepted safety for use under medical supervision.

(2) The board of pharmacy shall place a substance in Schedule II if it finds that the substance has: A high potential for abuse, currently accepted medical use in the United States, or currently accepted medical use with severe restrictions, and that abuse may lead to severe psychological or physical dependence.

(3) The board of pharmacy shall place a substance in Schedule III if it finds that the substance has: A potential for abuse less than the substances listed in Schedules I and II, currently accepted medical use in treatment in the United States, and that abuse may lead to moderate or low physical dependence or high psychological dependence.

Examples of drugs listed in Schedule I:

Heroin, lysergic acid diethylamide, marijuana, mescaline, peyote [with an exception for members of the Native American Church].

Examples of drugs listed in Schedule II:

Opium or opiate, and any salt, compound, derivative, or preparation of opium or opiate; coca leaves and any salt, compound, derivative, or preparation of coca leaves; Methadone, Amphetamine,

Methamphetamine; Methaqualone, Secobarbital, Pentobarbital, Phencyclidine.

Examples of drugs listed in Schedule III:

Any material, compound, mixture, or preparation which contains any quantity of Amphetamine . . . Methamphetamine, its salts, isomers, and salts of isomers. Any material, compound, mixture, or preparation which contains any quantity of [certain substances] having potential for abuse associated with a depressant effect on the central nervous system. These include: amobarbital, secobarbital, pentobarbital, and any quantity of a derivative of barbituric acid, except those substances listed in other schedules, e.g. Lysergic acid. Any material, compound, mixture, or preparation which contains any quantity of the following substances having a potential for abuse associated with a stimulated effect on the central nervous system. These include: Benzphetamine, Chlorphentermine, Clortermine, Mazindol. Any material, compound, mixture, or preparation containing limited quantities of . . . codeine, dihydrocodeinone, ethylmorphine, opium, morphine.

